Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Marylan		tificate of L			Reg. No.2 0	0 39001
	01 -1-1		1. Decedent's Name (First, Middle, Las	7)				2. Date of Dea Month	Day Yes	
	Physicia /Medic	al -	Helen W. Geiger						er 22, 201	.0 7.25
-	Examin	er '	la. Facility Name (If not institution, give		I.ama	4b. City, Town, or	George's			
and.			Collington Episo 5. Social Security Number 6. Se			If Under 1 Year	e11vi11e	8 Date of Birl		
	Funeral Director		117-03-6030	□M 2⊠F 100	Yrs.	Months Days	Hours Min.	June 13	3, 1910 NY	Birthplace (State or Foreign Country) City, NY
	pu »	i -	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Aaryla f sho	1 1		George's	4itche]	llville				1X Yes 2 □ No
	the N	irec	10e. Street and Number	30028		10f. Zip Code			10g. Citizen of What	t Country?
	h with	Funeral Director	10450 Lottsford	Rd, #247		207	21		USA	
	deat ems	iner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.
36	or it	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1		1∐Yes 2≹No	Specify:		Specify:	White
21215-0036	houn tural	ed	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	pation	dina	16b. Kind of Busine	ess/Industry
215	in 72	Completed	(Specify only highest gra		(Give life. i	kind of work done		rking	Priv	
21	d with	PO PO		College (1-4or 5+) 5+		Artist		(First Middle	e, Maiden Surname)	/ale
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experience round to notified at once.	Be	17. Father's Name (First, Middle, Last) Sigmund Winograd			:		Feldma:		
Σ	hould d Me mark matic	2	19a. Informant's Name/Relationship (19b. Mailir	ng Address (Street	and Number or F	Tural Route Numb	per, City or Town, Sta	ate, Zip Code)
\geq	alth ar 27 is r trau		Mark S. Morgan			Glydon S			VA 22180	
ē,	s 1 and 2 of Health of Item 27 is other tra		20a. Method of Disposition	20b. I	Place of Dispo	osition (Name of matory or other place	ce)	Date	20c. Location - Cit	y or Town, State
m ₀	Pages nent of ant: If Its ury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			tan Crema		26/10	Alexandri	La, VA
Baltimore,	permit. Page Department Important: If any injury o		21. Signature of Funeral Service Licer	see		2. Name and Addre		D. A	4739 Bal	Ltimore Avenue
ш	20 E 8 8		23a. Pert1. Enter the disease, or com	First and the desired the deal						Approximate Interval Between
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		ter the mode or dyr	rig, sacri as caran	20 01 100p// atoxy		Interval Between Onset and Death Years
	Physician // Medical		disease or condition resulting in death)	a. Lung neop1 Due to (or as a consec			<u> </u>			years
-	Examiner			b	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):					
	ecute and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consec	mence of).					
60,	be exician a	E	Tooling in down, and	Due to (or as a consec	querios oi).					
68760,	tificate be executed ig physician and as the burial-transit	edical		d						
Вох (anding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		☐ Ectopic pregnan	icv		23d. Date of	
	death ce	sicia	in the past 12 months? 1 ☐ Yes 2 🖾 No	4 ☐ Pregnant at time of		Other (specify)			Month	1 Day Tea
P.0	that the death cer led by the attendin detached for use	Physician/	9 ☐ Unknown Part II. Other significant conditions		sulting in the I	ınderlying cause gi	iven in Part I.	23e. Did	I tobacco use contrib	ute to the cause of death?
Š	ires the signeral libe d		Part II. Other significant conditions	Contributing to death but not to	January III III I			1 🗆]Yes 2 □ No 3	☐ Probably 🏄 🖺 Unknown
Records,	w requires to been signer should be a	Completed by						24a. Wa	is an 24b. We	ere autopsy findings available or to completion of cause of
Rec	e la has	du							formed? dea	or to completion of cause of ath? □Yes 2 □ No
of Vital	ician: The certificate ector, pag		25. Was case referred to medical				26. Place of D	eath (Check only		1100 12110
Ϋ́		o Be	examiner? 1 Yes 2 XNo	Hospital: 1 ☐ Inpatient 2 [☐ ER/Outpatie	ent 3 DOA Ot	ther: 4K Nursing	Home 5□ Re	sidence 6 Other	(Specify)
0	ng Ph fter th neral	Du: 1	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time Injury	Wo	ury at ork?	28d. Describe	e how injury occurred	i
Sio	eath. or: A the fu	catic	2 Accident investigation 3 Suicide 6 Could not be				∃Yes 2 □No	28f Location	(Street and Number	or Rural Route Number,
Division	or Att	Certification: To	4 Homicide determined		nome, tarm, s sify)	treet, factory, office	•	City or T	own, State)	or right floate realization
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this Completely filled in by the funeral di	Medical Ce	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my kr miner: On the basis of examin and manner stated.	nowledge, dea	ath occurred at the investigation, in my	time, date and play opinion, death or	ace, and due to the	he cause(s) and man ie, date and place, ar	nner as stated. nd due to the cause(s)
	o the vithin o the omple	Med	29b. Signerure and title of dertifier	A STREET, SERVER.			nse number			(Month, Day, Year)
	10		> \ /	yers my		D	32261		11/24/	10
	,0		30. Name and address of person who							
			Richard J. Feldm			uck Rd, I	anham, N	D 2070	ь	
	S Regis	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign						
	negis	(DOO:	NOV 2 9 2010	was p. ga	ve					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:53 A M Norman Franklyn Gibbs November 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's 35731 Golf Course Drive Mechanicsvill Year If Under 24 8. Date of Birth 9. Birthplace (State or Foreign Funeral Social Security Number 7. Age (In vrs. last birthday) 1 XM 2 🗆 F (Month, Day, Year) une 26, Months Days Hours Mary Land 85 219-16-0304 June Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a, State 10c. City. Town or Location must be notified at within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland ST. Mary's Mechanicsville 10f. Zip Code 5 10e, Street and Number 10g. Citizen of What Country? 23a Funeral 35731 Golf Course Drive 20659 United States items 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married 0 þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White "natural" Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Elevator Mechanic Elevator Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carlos D. Gibbs Ethel E. Steele 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis J. Gibbs/Wife Golf Course Drive, Mechanicsville, MD 20659 permit. Page 1 and 2 Department of Healt Important: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State any injury or Lakemont Memorial Park 12/2/2010 Davidsonville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Prinsfiell-Echols F.H., P.A., 21. Signature of Funeral Service Licensee MO0817 30195 Three Notch Rd., Charlotte Hall, MD 20622 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Error Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): Fibrillation Cancer VIAU To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 🗌 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify ည 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar 29b. Signature ar

Manoj

30. Name and address

Dhansukh1a1

DHMH 17 Rev 7/2009

317767 Market Drive,

Charlotte Hall

person who completed cause of death (Item 23a) (Type, Print)

trar's Signature

Panwa1a

32. Reg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Decembe 1:55 PM RUTH MAE HUMBERTSON 2010 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Hagerstown Washington County Hospital If Under 1 Year | If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day une 10 , 1919 West Virginia 1 □ M 2 🛣 F Months Hours **Director** 220-10-8886 Jùne Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No Washington Maryland Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 750 Dual Highway 21740 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married Ď If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: 3 ₩ Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Semstress Dress Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas Jefferson Long Arbanna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Indiana Avenue, Hagerstown, Maryland 21740</u> Linda S. Swartz Dauahter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Commation 3 Removal from State Hagerstown Crematory 12-03-10 4 Donation 5 Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licenses ²²Andrew K. Corrman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, R. holl Bra Md. 21740 23a. Part 1. Enter the disease, or complications that caused the direct. Do not inter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on exchaine Immediate Cause (Final Wysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Month Year ed by the a 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed?

Yes 2 No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 14 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After t
completed filled in by the funera 28d. Describe how injury occurred work? 1 Natural 5 Pending injury Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar who completed cause of death (Item 23a) (Type, Print)

10-09206 Carter Hampton Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

arter Hampton		- For State	e of Maryla		artment of <i>rtificate of</i>			Mental Hy	_	Dog No	201	U	39004
Physician		Registrar 1. Decedent's Name (First, Middle,L	ast)						2. Date of De				3. Time of Death
Medical Examine		Carter Richar		ampton		4h Oit T		ocation of Death	Month Decembe		010 c. County of		0428 hrs
الر	ľ	4a. Facility Name (if not institution, of Howard County General		nber)	ľ	Colum		cation of Death		- 1	C. County of Howard	Deau	
Funeral			Sex 7	. Age (In yrs. I	ast birthday)	If Under		If Under 24Hrs. Hours Min.	8. Date of E	irth(MM	I/DD/YYYY)	Foreign	pplace (State or DC
Director	L		X M 2 F		Yrs		Days	Hours Will.	3/19/	201	0	Cou	^{ntry)} Washingt
a y	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locat	ion							10d. Inside City Limits
A	اج	MD Prince	George's	Laur	re1								1 X Yes 2 No
Maryland 28a-f show	Director	10e. Street and Number				10f. Zip (-	tizen of Wha		
death with the Maryland or items 23a or 28a-f sho must be notified at once.		9667 Horsham Dr		dent Consis II	6 [42 We		0723	anic Origin? (Sp	anif. Von or h		ted S		an Indian, Black,
ath wi	Funeral	11. Marital Status 1 XNever Married 2 Marrie	ed Armed For					Mexican, Puerto		10-	White,		an indian, black,
	힑	3 Widowed 4 Divorc	1 Yes ed If Yes, Give Year or Dates:	2 X No	1	Yes 2	X No	specify:			Specify:	Blac	:k
hin 72 hours after e. than "natural", edical Examiner		15. Decedent's Education (Specify	only highest grade College (1-					n (Give kind of w O NOT use retir		16b.	Kind of Bus	iness/In	dustry
36 hin 72 e. than '	Completed	Elementary/Secondary (0-12)	College (1-	4 01 3+1				m	me				mone
5-0C led wit Hygien other		17. Father's Name (First, Middle, La	•					.Mother's Name	(First, Middle		n Surname)	,	
21215-0036 ould be filed within 7 Mental Hygene, marked other than ic event, the Medica	99	Monte Frank 19a. Informant's Name/Relationship	Hampton		19h Mailing	Address		Erica R: and Number or F			City or Town	State	Zin Code)
i, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygene. tem 27 is marked other than "natural", or items 23a or 28a-fable transmantic event, the Medical Examiner must be notified at once	2	Erica R. Hamptor		r)	1/2/11	Hors			urel, N			,	
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygene. Isant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examined To D. Commisched have	- 1	20a. Method of Disposition 1 Burial 2 Cremation	3 Removal fro		Place of Dispos crematory or oth		e of ceme	tery,	Date	20c.	Location -	City or T	own, State
Baltimore, permit. Pages I an Department of He important: If its mijury or other tr	- 1	4 Donation 5 Other Speci	ify:	For				ery 12/			rentw		
Baltimo permit. Page Department of Important: injury or ott		21. Signature of F heral Service Lic	ensee		_			fFacility For					
Physician	+	23a. Part I. Enter the disease, or con		sed the death									Approximate Interval Between Onset and
/Medical	1	failure. List only one cause on Immediate Cause (Final disease		ac Arr	hythmia	due	to A	nomalou	s Coro	nary	Arte	ry	Death
a_xansiner	1	or condition resulting in death)	Due to (or as a	consequence o	f):						- nonewa		
	اةِ	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence o	f):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c	consequence o	f):								
executed an and al - transit	ᇍ		d	00 07		010	0 10	2 11 .					
sici pe	edical	X UNPENDED			per me	g912	2-18	8-11 v t		Las			
876 tificate ng phy as the b	<u>\$</u> ₂	IF FEMALE: 3b, Was decedent pregnant in the past 12 months?	23c. If yes, or	utcome of preg th		tal death	3	Ectopic pregna	ncy	23	3d. Date of o Month	delivery Da	ay Year
Box 68760, s death certificate be the attending physici of for use as the buri	Physician/M	1 Yes 2 No 9 Unkno		int at time of de	eath 5 Ot	her (Specia	fy)						
- 8 5 6 1 7		Part II. Other significant condition			esulting in the u	ınderlying	cause giv	en in Part I.	23e. Did	tobacco	use contrib	oute to ti	ne cause of death?
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the rafter death. al Director: After this certificate has been signed by the funeral director, page 2 should be deadded in the fineral director.	<u>ğ</u>								1 🗌 Y	es 2	✓ No 3	Proba	ably 4 Unknown
aw requi	Completed									opsy	pr	ior to co	opsy findings available empletion of cause of
Reco The law icate has page 2 sl	Ę								1 Yes	formed?		eath? ✔ Yes	2 No
ital Rediction: The scentificate rector, page	å R	25. Was case referred to medical examiner?	Hospital: 1	patient 2	ER/Outpatient		10	f Death (Check of ther 4 Nursin	g Home 5	Reside	lence 6	Other:	
ling Physical directions of View this funeral directions of View this funeral directions of View tensor of View		1 ✓ Yes 2 No 27. Manner of Death	28a Date o		28b. Time of I		Bc. Injury		28d. Describe			-	
ion tendin eath. tor: A	틽	1 X Natural 5 Pending 2 Accident Investig	1	Day, rear)		-u	1 Ye	s 2 No					
Divisi pital or At ours after d neral Direct filled in by	Certification:	3 Suicide 6 Could n	ot be 28e. Place	of Injury - At h	ome, farm, stree	et, factory,	office buil	lding, etc.	28f. Location or Town,		and Numbe	r or Run	al Route Number, City
bou hou	-	4 Homicide 29a. Certifier	lclan: To the best	of my knowled	ge death occur	red at the t	ime date	and place, and	due to the ca	use(s) a	nd manner	as state	d.
Division To the Hospital or Attent within 24 hours after death To the Funeral Director completely filled in by the	Medical		ner:On the basis of and manner sta	examination a									
To To Con	ğ	29b. Signature and title of certifier	1 11	S.			License r						th, Day, Year)
		Aflen /s	mlf. 10	NA			O.C.M	.E.		De	cember 2	<u> </u>	0
2		30. Name and ∕address of person wh Melissa Brassell, MD	io completed cause Assistant Med			enn Stre	eet, Ba	Itimore, MD	21201				
Stat	te	31. Date filed (Month, Day Year)	32. Rec	gistrar's Signal	ure //		-						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 15. 2010 0115 W. HOPKINS Medical JAMES. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S HEIGHTS CAPITOL 5278 MARLBORO PIKE If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min 216-92-2624 1 M 2 D F 11/924/1967 42 Washington, D.C. Director Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Prince Georges Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20743 United States 5278 Marlboro Pike 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1x Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 🗌 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Construction Worker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James W. Hopkins Brenda Marie permit. Page 1 and 2 should by Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Hopkins/ Mother 5278 Marlboro Pike Capitol Heights, Md. 20743 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park 11/24/2010 Riverdale, Md. 22. Name and Address of Facility
Alexander S. P.
5538 Marlboro 21. Signatur of Funeral Service Lice exe PPPe/P Forestville, Md. 20747 004010 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Dotogri Physician/ disease or condition resulting in death) MUCCINUME Medical Due to (or as a consequence of) Examiner Sequentially list conditions If any leading to immedicause. Enter Underlying Due to for as a consumence of Exami the attending physician and hed for use as the burial-transit requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown 1 ☐ Yes 2 L 9 ☐ Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law is within 24 hours after death.

To the Funeral Director, After this certificate has be completed filled in by the funeral director, page 2 si autopsy performed Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1

Yes 2 □ No Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 1 Inpatient 2 I ER/Outpatient 3 I DOA ည 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one License number 29d. Date signed (Month, Day, Year) hature

State Registrar 30. Name and address of pe

31. Date filed (Month, Day, Year)

NOV 2 9 2010

DHMH 17 Rev 7/2009

son who completed cause of death (Item 23a) (Type, Print)

しいい

32. Registrar's Signature

15

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra 39006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Fannie Jeanette White Hawthorne ^{Day} **21.** 2010 November 7:45 A. Medical Facility Name (if not institution, give street and number)
Independence Court of Hyattsville **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hyattsville Assisted Living 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗶 F Months Days Hours Min Day Year) **924** 189-12-8453 86 Director April Pennsylvania Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director **Maryland** Prince Georges 1 X Yes 2 No Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with Funeral 5821 Queens Chapel Road; Apt. 210 20782 United States within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ģ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" **Black** 3 X Widowed 4 □ Divorced Specify. Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene, other than " U.S.Dept. of Navy/Naval Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with.
Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic conce. 3 years Physical Science Technician Oceanographic Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John Frances Matthews 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeannette Hawthorne Morsell 811 Sero Pine Lane; Fort Washington, Maryland 20744 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Nov. 29 4 Donation 5 Other (Specify) Lincoln Memorial Cemetery Suitland, Maryland 21. Signature of Funeral Service Lives e 22. Name and Address of Facility R. N. Horton Company Morticians, Anc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Chysiciani Large B Cell Lymphoma Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Month Unknown 9 X Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Cerebrovascular Accident 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? Diabetes Mellitus 24a. Was an autopsy perform Failure to Thrive Yes 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No Assited Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural (Month, Day, Year) 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be To the Hospital or Atta within 24 hours after de To the Funeral Directo completed filled in by ti Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 29a. Certifier 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bindu Joseph, M.D.;1160 Varnum Street, N.E.; Suite 021; Washington, D.C. 20017

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

park

MD33755

November

24, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 6:54 AM Richard Glen Hunsucker 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Worcester Berlin g. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 228-54-0504 70 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Newark Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral 21841 USA 8416 Langmaid Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Maryland 21215-003 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Carpentry Contractor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Magdelene Hogg James Hunsucker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Hunsucker/Brother 8416 Langmaid Rd., Newark, MD 21841 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition DO 8 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Garden 11/24/2010 Newark, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Burbage Funeral HOme 108 William St., Berlin, MD 21811 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ restat disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE Live Birth 2 Fetal death 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown been signed by the salvould be detached 9 Unknown Hunsuck Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 After this certificate has funeral director, page 2: death? To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h 1 Yes 2 No 26. Place of Death (Check only one) Division of Vital 25. Was case referred to medical Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury_at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Richard completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifler (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 11/21/2010 0064120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Berlin MD 21811. 9733 Health Way Zeeshan 32 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 3 2010 Registrar

1-4

87

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Physician/ 6:42 P M 2010 Hutchison Mae Betty Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Anne Arundel Riva 527 Laurel Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Mary land 1 □ M 2 💢 F Yrs 579-28-7514 83 **Director** Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 🗌 Yes 2 💢 No MD Riva Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21140 527 Laurel Road Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes If Yes, Give _2 😿 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) own home 12 homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Nettie В. Ausherman Lester 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Laurel Road. Riva, MD Don C. Hutchison, spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 11-23-10 Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): cause. Enter Underlying n and al-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician () for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 month Month Dav Year Pregnant at time of death Other (specify) signed by the a a
Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director; After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred Natural 5 Pending 2 🗌 No Investigation Accident Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 29b. Signature and title of dertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RW 10 Jack Lichtenstein, M.D., 205 Ridgely Avenue, Annapolis, MD 21401 31. Date filed (Month, Day, Year) 32. Registra s Signature State NNV 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 11/21 / 2010 ear 11:15 am Effie May Bosley Hicks Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Hours 07/31/192 1 M 2 X 89 **Director** 214-12-4002 Usual Residence of Decedent r 28a-f show notified at show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 ☐ Yes 2 🛣 No MD Harford Forest Hill 10e. Street and Number 10g. Citizen of What Country? items 23a or ner must be n Funeral 304 Whetstone Road 21050 within 72 hours after death . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S 11 Marital Status "natural", or iten edical Examiner r Black, White, etc. Armed Forces 1 Yes 2 No If Yes, Give ρ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify Specify: White 3 XXWidowed 4 □ Divorced Completed Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natu ury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Self Employeed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sherman Bosley Mary LuLucinda Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Kessler/Daughter 8440 Meadowview Circle, Owings, MD 20736 Department of Health Important: If item 27 any injury or other tronce. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lee Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/23/2010 Clinton, MD Sign due of Fue ral Service Licensee 22. Name and Address of Facility 8125 Southern Md Blvd vd, Owings MD 20736 Lisa M. Mounts Lee Funeral Home Calvert 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE MYOCARDIAC Ph sician/ INFACTION M NOT! disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DRUNARY ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Dav Pregnant at time of death 5 Other (specify) ed by the a g Unknown P.O. I signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FIBRILLATION The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown HYPERTENTION. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 HISTORY 1 Yes 2 No Division of Vital Hospital or Attending Physician: nin 24 hours after death.

the Funeral Director, After this certific

mpleted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Investigation Could not be 2 Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

To the by within 2 To the F complet

State Registrar 29b. Signature and title of certifier

OKEOWO 31. Date filed (Month, Day, Ye

D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IBITOYE

anward

2 Gettiying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

INT MED.

GLENNDALE

29d. Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year ELOISE **EDNA** HORSTMAN 1325 M Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Peninsula Regional Medical Wicomico center If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 M 2 XF Months Hours Min. (Month, Day, Year) 06/15/1934 Country) **Director** 216-32-2530 76 Yrs. New Jersey Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico 1 X Yes 2 No Salisbury 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 315 Beaglin Park Drive 21804 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 - Widowed 4 - Divorced Specify: White Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) e 1 and 2 should be filed within 72 It of Health and Mental Hygiene.
If item 27 is marked other than "re orther traumatic event, the Med (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cook/Hostess Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any injury or other traumatic. Hinrich Amandus von Staden Alida Marie Sjoers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. Horstman (Husband) 315 Beaglin Park Drive - Salisbury, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Sunnyridge Memorial Park 11/28/2010 4 ☐ Donation 5 ☐ Other (Specify) Crisfield, MD 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, Bradshaw Robert 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Esophageal Ruphire disease or condition) Medical resulting in death) Due to (or as a consequence of): Examiner Heurt 70 mg mediashind Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 L 9 Unknown 9 Unknown P.0. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No certificate 2 🗌 No 1 Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a
To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as examined. 29b. Signature and title of certifier 29c. License number MKZ 0 47044 11/26/10

DHMH 17 Rev 7/2009

State

Registrar

#2320FIF

NATESAN

1415 5 DIVISION

Svecu

SACISA My

M 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 2 9 2010

31. Date filed (Month, Day, Year)

Vel

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Kevin James Hadwin 2:15 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b City Town or Location of Death 4c. County of Death Cecil Port Deposit 43 Orchard Drive 5. Social Security Number 6. Sex 1 X M 2 D F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 218-06-1433 26 Maryland Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City Town or Location 10d. Inside City Limits Director Maryland Port Deposit Cecil 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21904 U.S.A. 43 Orchard Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🌠 No Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Maryland 2121 life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) never employed Twelve Years never employed other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Janet E. Mischler Dale I. Hadwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet E. Kennedy 43 Orchard Drive, Port Deposit, Maryland (mother) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🖔 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) ò 11/23/10 Rising Sun, Maryland Ebenezer Cemetery injury Signature of Funeral Service Licen Lee A. Patterson & Son Funeral Home Perryville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus ____n each line. Onset and Death Immediate Cause (Final Physician/ moni disease or condition resulting in death) Medical Examiner Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death been signed by the should be detached if 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perform death? performed?

1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 X No Other: မြ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical

To the Funeral Director: After this certifics completed filled in by the funeral director, i

Marne and address of person who completed cause of death (Item 23a) (Type, Print) MD loria 31. Date filed (Month, 32. Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month,

Dav. Yearl

State Registrar (Check

only one

Signature and fittle of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Day William Hall 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8814 Doris Drive Prince George's Fort Washington 7. Age (In yrs. last birthday) 63 yrs. 8. Date of Birth (Month, Day, May 9, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Min. 424-66-5544 1 🕅 M 2 🗆 F Director 1947 labama Jsual Residence of Decedent 28a-f show aţ 10c. City, Town or Location 10d. Inside City Limits Director notified MD Prince George's Fort Washington 1X Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ral", or items 23a or Examiner must be Funeral 8814 Doris Drive 20744 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. "natural", or þ 1 Never Married 2 Married Yes 2 x No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: Black Completed 3 Nidowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Telecommunications Specialist traumatic event, the Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ပ Unknown Genie W. Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2217 S. Street S.E. Washington, DC 20020 Ila Ruth Best/Friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 12 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 11/22/2010 4 Donation 5 Other (Specify) Washington National Suitland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home > man 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Advanced AIDS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) physician and s the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No signed by the a 9 Unknown 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🗚 🗓 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page, Hospital or Attending Physician: The 1 Yes 2XX No 2 🔀 No of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 🗵 Residence 6 Other (Specify) 2 No 1 Tyes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Division 2 🗌 No 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 2 4 11/15/2010 D45471 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Dr. Yeheyis Negussie,

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

32. Registrar's Signature

MD 1111 Spring Street Suite 214 Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 14721/2010 ODELL HICKSON 0900 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 1 M M 2 □ F 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours Country) 04/07/1929 Director 249-46-7399 81 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 72 hours after death with the Maryland Director 1

Yes 2 □ No MD Prince George's Laurel 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12239 Apache Tears Circle 20707 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1951-Black, White, etc. and Mental Hygiene. is marked other than "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Specify: Black 3 Widowed 4 Divorced 1953 Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of College (1-4 or 5+) Elementary/Seconday (0-12) Agriculture 10th Equipment Operator Be permit. Page 1 and 2 should be filed bearing of Health and Mental Hy, Important: If item 27 is marked oth any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Alberta White Solomon Hickson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13994 Tanners House Way, Centreville, VA 20121 Klaretta Fowler - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Quantico Nat'l Cem 11/29/10 Triangel, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Snowden Funeral Home 21. Signatur Juneral Service Licenses 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one pause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 1 ☐ Yes ≥ L g ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 Ko 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law in 24 hours after death.
the Funeral Director: After this certificate has the Funeral Director: After this certificate has the principle of filed in by the funeral director, page 2 s. autopsy performed? 1 Yes 2 1 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ickson, ODELL 2 **P**No 1 Inpatient 2 ER/Outpatient 3 DOA 잍 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) Eno, MD 0057124

State Registrar

DHMH 17 Rev 7/2009

Truong Bao 1 31. Date filed (Month, Day, Year) #206, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 2 4 2010

10110 Molecular Drive,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day 2010 **Physician** P^{M} Walter Howard Hutson, Jr. Nov. 30. 1:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester Mallard Bay Center Cambridge If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr. 29,1945 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Months Days Hours 1 X M 2 □ F Maryland 216-44-8456 65 Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City. Town or Location show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov ury or other traumatic event, If a Me Jich Examinar mant to 1 citified at 1 XYes 2 No Director Maryland Dorchester Vienna 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21869 128 Market Street Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 🗓 No If Yes, Give Year or Dates: Specify: White Completed by 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Delivery Person Newspaper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Wise Walter Howard Hutson, Sr. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. 3750 Elliott Island Road, Vienna, Maryland 21869 Elizabeth Tyler/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/01/2010 Delmar, Delaware Crematory Of Delmarva 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, 21. Sign ture of Funeral Service Livinses 21631 Part /. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (us hone **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. E. for Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Physician/Medical attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 □ Yes been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 1 ☐ Yes 2 ☑ Ne 1 ☐ Yes 2 ☐ No Hospitallor Attending Physician: 7 24 hours after death. this certific 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 100 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral c 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Aatural 5 Pending investigation within 24 hours fler death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

State Registrar and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 47924

CAMBRIDGE MO

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day VOV. 25 be /Medical 010 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gadow +on aroline Birthplace (State or Foreign Country) (In yrs. last birthday) 8. Date of Birth (Month, Day, Age **Funeral** 1 M 2 F Months Days Hours Min. 215-20-4959 Usual Residence of Decedent NOV. 26, 1918 Director Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural" or items 23a or 28a-f show injury or other traumatic event, it is invested Examinated by notified at 1 ✓ Yes 2 ☐ No Director On 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 468 Funeral 2 6 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ 3 Widowed 4 ☐ Divorced Biack Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) County Board of 6 Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mental I 1 and 2 should b Health and Ment opper ပ္ Sherman -aura 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 i any injury or other tra Preston Maryland 2.
ate | 20c. Location - City or Town, State Landes 20a. Method of Disposition GADOW KOAN 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 22. Name and Address of acility 61 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Funeral Home, P.A. Shington St. Cambri dge, MD. 21613 10 Wa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed and burial-Box 68760. physician Physician/Medical the attending physical and the second IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.0. the þ signed I Part II. Other significant conditions contributing to 23e. Did tobacco use contribute to the cause of death? death but not resulting in the underlying cause given in Part I Records, þ 1 ☐ Yes 2 ♠ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy To the Hospital or Attending Physician: The certificate performed Division of Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No 5 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner eath 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 Latural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of contile License numbe 29d. Date signed (Montyl, Day, Year)

State Registrar 31. Date filed (Month, Day,

an

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra 1/29/10 Amended 29b ekt Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month **Physician** 2010 awana VOV nn Man /Medical 4c. County of Death 4a. Facility Name (If not institution, give seet and number) 4b. City, Town, or Location of Death Examiner Dovehester

9. Birthplace (State or F Mallard 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 1 □ M 2 12 F Days Hours Min. 218-84-670 Usual Residence of Decedent -84-6708 Months May 27, 1969 Director 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mexical Examiliar must be troffled at 1 PYes 2 No Director Dorchester ambrid qe 10g. Citizen of What Country? 10e. Street and Number L 61 ree Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 2 If Yes, Give Year or Dates Specify Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) rocessing Poultry Line Worker Ld 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ton ပ HayMan Anthony 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cambridge, Maryland 21613 3910. 20c. Location - City or Town, State S 1123 High S 20b. Place of Disposition (Name of cemetery, crematory or other place) Street Deshield Marve 20a. Method of Disposition 12/3/10 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cambridge, MD. 4 ☐ Donation 5 ☐ Other (Specify) Bethel Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address Facility Henry Funeral Home, RA. 510 washington Str Cambridge, MD121613 Approximate Interval Between Oncet and Death 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** PACS blastomA near /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760. physician Physician/Medical the use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy ģ in the past 12 months? 1 □Yes 2 ₩ o Month Year 5 ☐ Other (specify) P.O. ed by the a 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Ohale 3 ☐ Probabiy 4 ☐ Unknown 1 ☐ Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed page After this certificate funeral director, page Th ron wosis 2 1 1 □ Yes Division of Vital 2 🗆 1 🗆 Yes Physician: 25. Was case referred to medical examiner?
1 Yes 2 Yes Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death

1 Matural

2 Accident 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending (Month, Day, Year) 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fur after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 23 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cambridge KARR D.01 51 60,5 100 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 24, 2010 Gordon T. 1:45 p.M Henderson November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Homewood at Crumland Farms Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/11/1921 Birthplace (State or Foreign Country) 1 MM 2 □ F Months Days 88 391-12-1368 Wisconsin Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2▼No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7407 Willow Road, #156 21702 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Specify Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Federal Elementary/Secondary (0-12) College (1-4or 5+) Aviation engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James T. Henderson Hannah Knoke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) G. Scott Henderson / son 6379 St. Timothy's Lane, Centreville, VA 20121 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Smithsburg Crematory 11/26/2010 Smithsburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home Japulle Mul MO1222 106 E. Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PROSTATE 10 YRS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a. Was an autopsy performed? 2 3 No 2 No 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

Be Completed by

P

MD

Funeral

Director

tem 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be i

Health and Mental Hy

em 27 is marked

permit. Pages 1
Department of He
Important: If iten
any injury or oth

Maryland

Baltimore,

Vital

0

Top

0

Physician/Medical Completed by

Certification: To

9 Unknown

HYPOTHYRAD

IL Yes 2	0
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending investigation 6 Could not be determined

(Check only one)

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Iniury

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Done kon	mo
----------	----

121936

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. DONELSON. AD BJC THOMAS UDHNSON DR. FREDERICE, MD 21702

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

To the Hospital of within 24 hours at To the Funeral D

4+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U ! U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26, 2010 2:44 p. M Pickford Hockaday Margaret November 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Callaway Hospice House of St. Mary's If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1 □ M 2 🛚 F 01/27/1925 Months Days Hours Min. Washington, DC 578-20-8196 85 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Tes 2 X No Maryland St. Mary's Leonardtown 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? United States 20650 22594 Greggory Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home

Physician/ Medical Examiner

Physician/

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important, if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Medical

10a. State

Director

Funeral

Completed by

the attending physician and hed for use as the burial-tran

Division of Vital Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours. Her death
with the Function of the this certificate has been signed by the attending physician and To the Function theoton. The this certificate has been signed by the attending by the burial-transi completed filled in by the funeral director, page 2 should be detached for use as the burial-transi

De	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)							
2 │	John Withers English		Agnes Payr	ne						
	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street	and Number or Rural R	Route Number, City o	or Town, State, Zi	p Code)				
	Peggy Lee Ritter/Daughter									
	20a. Method of Disposition 20b. Pl	Location - City or	Town, State							
	Burial 2 La Cremation 3 La Remova nom State	emetery, crematory or other place nsfield-Echols	1	/2010 Cha	rlotte H	Hall, MD				
	21. Signature of coneral Service (1. as e		ess of Facility Brin							
	Edward N. Brinsfield, Jr. M000	052 22955 Hol	lywood Rd.	, Leonard	ltown, M	D 20650				
	23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not enter the mode of dyir	ng, such as cardiac or re	espiratory arrest,		Approximate Interval Between				
	Immediate Cause (Final disease or condition	ancer				Onset and Death				
	resulting in death) a. Due to (or as a series equi-									
2	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	enne cry								
Examine	Cause (Disease or iinjury that initiated events C.									
	resulting in death) Last Due to (or as a consequence of the control of the contro	ence of):								
alcal	d									
ĕ	IF FEMALE:				+					
Clair	23b. Was decedent pregnant 23c. If yes, outcome of pregnant	ncy Ideath 3 🗆 Ectopic pregnan	cv	23d. Date of de	elivery Day Year					
5		in the past 12 menths?								
Z Y		100 - 1	In Book I	11		1.11.0				
ò	Part II. Other significant conditions contributing to death but not resu	uiting in the underlying cause gr	ven in Part I.			the cause of death?				
De la		-		1 ∐ Yes	2 ∐ No 3 ∐ F	Probably 4 Jnknown				
Completed by				24a. Was an autopsy	prior to	topsy findings available completion of cause of				
5				performed?	death?	s 2 PNo				
e	25. Was case referred to medical examiner?	26. P	lace of Death (Check or			Hospice				
0	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient 3 DOA Oth	er: 4 Nursing Home	e 5 🗆 Residence	6X Other (Spec	House				
e e	27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year)	28b. Time of 28c. Injury worl	y at 280	d. Describe how inju	iry occurred					
cermicate	2 Accident Investigation 3 Suicide 6 Could not be		Yes 2 ☐ No							
e	4 Homicide determined 28e. Place of Injury - At hor building, etc. (Specify)	28	f. Location (Street a City or Town, Stat		ıral Route Number,					
-										
29a. Certifier (Check or by tree) 3 Certifier 4 Deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
ž	only one) 3 Certifying Nurse Practioner: To the best of my 29b. Signature and title of certifier	knowledge, death consisted at the 29c. Licens			(a) and matter as					
	255. Organical of and time of certifier	25c. Licens	o number	29d. L	ate signed (World	II, Day, Teal)				
	30. Name and address of person who completed cause of death (Item 28103 Mrce No the 131. Date filed (Month, Pay, Year) 32. Joistrar's Signature	D G	3047	, , , ,	11/29	110				
	30. Name and address of person who completed cause of death (Item	23a) (Type, Print)	Mari	zer Bai	ner 111	159				
اات	31 Date filed (Month Day Year)	A STE 101	Necron	-30116/	0 0	10601				
2	31. Date filed (Month, Day, Year) 0 2010 32. Gistrar's Signature 1 32. Gistrar's Signature 2 32.	B. park				3				

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30, Physician/ 2010 5:05 a.mM. November William Benedict Herbert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Leonardtown St. Mary's Hospital Social Security Number 6. Sex 1 ፟፟ M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 08/02/1934 Mary Land 218-34-5580 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 X No Coltons Point Maryland St. Mary's 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral United States 20626 20614 Coltons Point Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. "natural", or ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced **Black** permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturaly injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Concrete Mason 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nellie Eleanor Armstrong Joseph Edward Herbert, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20626 20614 Coltons Point Road, Coltons Point, MD Mary Ann Herbert/Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 \fbox{M} Burial 2 \square Cremation 3 \square Removal from State Sacred Heart Cemetery 12/04/2010 Bushwood, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 201 Shawn Aylesworth M01521 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine death certificate be executed use as the burial-transit that initiated events resulting in death) Last physician Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 1 Live Birth
4 Pregnant
9 Unknown Day in the past 12 months? Month Year Pregnant at time of death been signed by the should be detached 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached. Division of Vital Records, P.O. Part II/ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy PROSTATE CANCEL performed? 1 Tes 2 No Yes 2 No Be B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: |@ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year)
NOVE IN USE R 30, 2016 29b. Signature and title of certifier 29c, License number

Deme

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Redistrar's Signature

30 Name and address of person who completed cause of death (Idem 23a) (Type, Print)
PATRICIA GURNY, MD ST. MARYS HOSPITAL LEONARDTOWN, MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	ate of Marylan		artment of H tificate of D		nd Men	, ,	ne No.20	0	390	120
			Decedent's Name (First, Middle, Last)						Date of Death			3. Time of	Death
Physi Me	ician dica		Helen J. Ince					No	Month vember	Day 26 ,	20 1 0	9:30	АМ
Exar		7	4a. Facility Name (if not institution, give street a			4b. City, Town, or Location of Death					y of Death		
<u> </u>			45080 Blackistone Ci		10:41 1 1	Holly If Under 1 Year		Uro To s		St	. Mar		
Funer Direct		ľ	5. Social Security Number 6. Sex 1 1 M 2	7. Age (In yrs. la	91 Yrs.	Months Days			Date of Birth Month, Day, Ye IY 15, 19	19	9. Birthp Count Wisco	lace (State or ry) nsin	· Foreign
		- 1	Usual Residence of Decedent						,,				
yland f sho ed at		흕	10a. State 10b. County	10c. City	, Town or Lo						1	0d. Inside Cit	
e Mar r 28a notifi		E l	Maryland St. Mary's		Ho	11ywood		_	100	g. Citizen of	NA/In and Consum	1 🗆 Yes	2 IXI NO
vith th 23a o st be	1	<u>a</u>	45080 Blackistone Ci:	rc1e		2063	36		100	USA		uyr	
eath v tems er mu	١,	Funeral Director	11. Marital Status 12. W	as Decedent Ever in U.S med Forces?	3. 13. V	Vas Decedent of His Yes, specify Cuban	spanic Origin'	? (Specify \	Yes or No-	14. Rad	ce - America		
21215-0036 within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f sho , the Medical Examiner must be notified at			1 Never Married 2 Married 1	Yes 2 K No		Yes 2X No		uerto nicai	1, 610.)	1	ck, White, e /: Whit		
-00, ours a atural cal Ex		Completed by	3 🔀 Widowed 4 □ Divorced If Ye 15. Decedent's Educatio	ar or Dates.	16a Decec	lent's Usual Occupa	tion		16	b. Kind of E			
2157 n 72 h an "n Medi	1	ᇍ	(Specify only highest grade con		(Give I	kind of work done du O NOT use retired)	uring most of	working	10	D. KING OF E	ousiness inc	lustry	
Withii yajene rafer the the	ı I		Elementary/Seconday (0-12) Co	mege (1-4-51-54)	Owner	/ Operato	or			Mar	ina		
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at		To Be	17. Father's Name (First, Middle, Last) William J. Gorton						st, Middle, Mai rie Ing		re)		
d Mer mark matic	- [19a. Informant's Name/Relationship (Type, Pri	nt)	10h Mailin	g Address (Street a					Otato Zin C	la da)	
re, Marylanc I and 2 should be file Health and Mental I tem 27 is marked o other traumatic eve			David Ince/ Grandson		1	Blackistone				-	20636		
Ore, I teland tof Healt If item 2 or other		1	20a. Method of Disposition		lace of Dispo	sition (Name of natory or other place	Nov	Date vember	29. 20	c. Location	- City or To	wn, State	
imC Page ment tant: I	1		1 ☐ Burial 2 🗵 Cremation 3 ☐ Remore 4 ☐ Donation 5 ☐ Other (Specify)	al from Gtate	•	Crematory		010		exandr:	ia, Vir	ginia_	
Baltimore, Maryland 21215-0036 permit, Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", o any Injury or other traumatic event, the Medical Exam	ouce.		21. Signature of Funeral Service Licensee	adener)	22	. Name and Address	s of Facility M P.O.	Matting 270 L	ley-Gard eonardto	iner Fu	uneral ryland	Home, P 20650	.А.
		7	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus		n. Do not ente	r the mode of dying	, such as car	rdiac or resp	piratory arrest,			Approximate Interval Bety	
Priysicia	_			Ideko Cal Due to (or as a consequ	ano	ma of	- the	- Lu	ina		12	Onset and D	
Medic Examin	_	-	resulting in death)	Due to (or as a consequ	ence of):							1	
		<u>.</u>	Sequentially list conditions, b. —	Due to (or as a normal):	6006 NY						-		
ted 1 insit	٦.	Examiner	cause. Enter Underlying Cause (Disease or iinjury	200 10 10 00 00 00 10 10									
execu an and rial-tra		֡֡֞֜֞֞֟֡֓֞֡֡֞֜֞֡֓֡֓֞֡֓	that initiated events c. — resulting in death) Last	Due to (or as a consequ	onsequence of):								
'60 ate be executed bhysician and the burial-transit	.	dical	d								\rightarrow		
687 ertifica iding pl		ğ	IF FEMALE:	yes, outcome of pregnal						T			
Box 687 death certifica he attending p ed for use as i	25	Pnysician/Me	in the past 12 months?	☐ Live Birth 2☐ Feta ☐ Pregnant at time of d	Ideath 3	Ectopic pregnancy Other (specify)	/				ate of delive onth	-	'ear
the de		IS	1 Yes 2 N No 9 Unknown 9	Unknown									
ords, P.O. Be requires that the debeen signed by the should be detached	1	9	Part II. Other significant conditions contribut	ing to death but not res	ulting in the u	nderlying cause give	en in Part I.		23e. Did tobac			. 1	
'ds, equires sen sig ould b		ge						_	1 Yes	2 🗌 No	3 Prob	ably 4 X	Jnknown
COI law re has be e 2 sh	-	Completed						_	24a. Was an autopsy			sy findings a npletion of ca	
ital Reccidian: The law certificate has rector, page 2 s			25. Was case referred to medical						performe	No	1 Yes	2 🗌 No	
Vital ysician: is certific director,	- 1	0 Be	examiner? 1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \) Hospita	al: 1 🗌 Inpatient 2 🗍	EB/Outpotion	LOtho	ce of Death (one) 5 X Residenc	Oth	or (Cnosify		-
n of V ding Phys h. After this funeral di	- []		27. Manner of Death 28	a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury	at		Describe how i				
ion tendin eath. or: Afi the fur	- ,	<u> </u>	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Worth, Day, Todi)			Yes 2□No	0					
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		Certificate:	4 Homicide determined	e. Place of Injury - At ho building, etc. (Specify,	me, farm, stre	eet, factory, office			Location (Stree City or Town, S		er or Rural	Route Numb	er,
lospita hours uneral		Medical	29a. Certifier 1 Certifying Physician: 2 Medical Examiner: Or	To the best of my knowledge of examination	edge, death o	occured at the time,	date and place	ce, and due	e to the cause(s) and mann	ner as state	d.	nner stated
thin 24 the F the F mplet	:		only one) 3 Certifying Nurse Prace 29b. Signature and title of certifier	tioner: To the best of my	knowledge, o	leath occurred at the	time, date an	nd place, and	d due to the ca	use(s) and m	anner as sta	ited.	
75 W W O			235. Signature and title of certifier			750			290	. Date signe	GIZI		
) ene		-	30. Name and address of person who complet	ed cause of death (Item	23a) (Type, P	rint)	,			^	g - Case -		
1 Kr.			GURDECP .S.	(HITA BK	4 0	3415 Three	e Not	th Ko	oad C	aliter	nia.	nd a	0619
S Regi:	State Strai		31. Date filed (Month, Day, Year) NOV 29 201	32. Registrar's Signat	ure 	1							
- Ice		,	1101 47 201	U KRAWA	- FI	BALKE							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOV Month Physician/ $2\overset{\text{Year}}{0}\overset{\text{r}}{1}0$ JONES THERESA 1601 p Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince Georges Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) DC Days Months Hours Min. July 22 Year 942 Director 578-56-4214 68 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ Director injury or other traumatic event, the Medical Examiner must be notified 1 Yes 2 X No Suitland MD Prince Georges 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20746 2304 Gavlord Dr. or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Day CareProvider Private 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marker any injury or out Richard Simmons Mattie Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2304 Gaylord Dr. Suitland, MD Garland Jones - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 11-23-2010 Brentwood, MD 4 Donation 5 Other (Specify) Lincoln Cemetery: 21. Signature of Tuneral Service Licensee Marshall-March Funeral Home of Maryland Suitland, MD Suitland Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiaç or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and -transit Exami that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No Month Day Year 4 Pregnant at time of death 9 Unknown ed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 1 Yes 2 No certificate To the Hospital or Attending Physician: Within 24 hours after death.

Je the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 1 Inpatient 2 ER/Outpatient ၉ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Natural (Month, Day, Year) 5 Pending 1 Yes 2 No М Investigation 6 Could not be ☐ Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NS/1616

DHMH 17 Rev 7/2009

State Registrar 31: Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / De State Registrar	partment of Health and ertificate of Death		ene g. No. 2010 39022
	Physici		1. Decedent's Name (First, Middle, Last) Melvin Jeffers		2. Date of Death Month November	
-	/Medic Examir		4a. Facility Name (If not institution, give street and number) Ft. Washington Hospital	4b. City, Town, or Location of Dea	n	4c. County of Death Prince Georges
	Funeral Director		5. Social Security Number 226-48-9709	Months Days Hours Min		9. Birthplace (State or Foreign South Hill, Va
:	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Modical Expranduct rust be notified at once.	Funeral Director	10a. State 10b. County 10c. City, Town or	Location Shington 10f. Zip Code	10	10d. Inside City Limits 1 → Yes 2 □ No g. Citizen of What Country?
	23a or	ral Di	2209 Steuben Ave.	20744		United States
936	al", or items	by Fune	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates;	 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puel 1 ☐ Yes 2 No Specify: 	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
Baltimore, Maryland 21215-0036	han "nature"	Completed by	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of wo p. DO NOT use retired)	orking 1	6b. Kind of Business/Industry
d 2	Hygie other t	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Na	un-avail. ame (First, Middle, M	un-avai
ylan	Mental Mental arked atic ev	To B	Walter Peace Jeffers	Lucy D	rumgo1v	
Mar	traum			ailing Address (Street and Number or F		
re,	f Healt tem 2			O Steuben Ave. Ft. position (Name of rematory or other place)		on, Md. 20744 Oc. Location - City or Town, State
e l	nent o			l Veterans 12/	/1/2010	Cheltenham, Md.
Balt	Departr Departr Importa any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Alexander S. Pope 5538 Mariboro Pik	è/ ^P förest	ville, MD. 20747
	hysician		23a. Part : Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a Pulmonary Emboli	enter the mode of dying, such as cardia	ac or respiratory arre	st, Approximate Interval Between Onset and Death
	/Medical xaminer		resulting in death) Due to (or as a consequence of):			
), overited	physician and s the burial-transit	Examiner	Sequentially list conditions, if and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Lun Disease Due to (or as a consequence of): Myocardial Infar Due to (or as a consequence of):	ction		
68760,	g physicia as the buri	dical	d			
I Records, P.O. Box 68760, The law requires that the death certificate he executed.	ned by the attending p detached for use as	Physician/Me		B ☐ Ectopic pregnancy D ☐ Other (specify)		23d. Date of delivery Month Day Year
ords, P.	been signed b	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
		Completed			24a. Was an autopsy perform	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No
Vita	certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:		eath (Check only one	
Division of Vita	th. : After this s funeral dir	ition: To	1 ☐ Yes 2 🛣 No ☐ Tospitat. 1 ☐ Inpatient 2 至 ER/Outpati 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation ☐ Solution (Month, Day, Year) ☐ Injury	of 28c. Injury at	Home 5 Resider 28d. Describe how	ce 6 Other (Specify) rinjury occurred
<u> </u>	# = -	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
The Hospital	within 24 hours at To the Funeral D completely filled i	edical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occ	ce, and due to the ca curred at the time, da	use(s) and manner as stated. e and place, and due to the cause(s)
P	with con t	Ž	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year)
	10	-	63	D0065385		November 19, 2010
	47		30. Name and address of person who completed cause of death (Item 23a) (Type Alex Rosin, M.D. 11711 Livingston	e, Print) Rd. Ft. Washingto	on, Md. 2	0744
ş	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 1:50 P M YVETTE MARIA JACKSON 11 12 2010 /Medical 4a. Facility Name (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2875 MERCHANT COURT WALDORF CHARLES COUNTY If Under 24 Hrs. 8. Date of Birth (Month, Day, If Under 1 Year 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Months Days 1 M 2 X F 12/02/1969 Director 339-66-8151 40 ILLINOIS Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Impuries Event. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD CHARLES WALDORF 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2875 MERCHANT COURT 20603 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2**X** No Specify Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SUPPLY TECHNICÍAN US ATR FORCE 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LEO CRAWFORD VIVIAN BROWN ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES JACKSON/HUSBAND 2875 MERCHANT COURT WALDORF, MD 20603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory11/24/2010 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARSHALL-MARCH FUNERAL HOME 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Year 4 Pregnant at time of death Month Day 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes □No 24a, Was an autopsy performed Yes 2 certificate 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Deat Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 No illed in by the f 2 Accident 6 ☐ Could not be 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [29a, Certifier Light Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

State Registrar

29b. Signature and title of certifie

0

31. Date filed (Month, Day, Year) 32. Registrar's Signature

70

DHMH 17 Rev 1/2001

29c. License number

MATHUR,

M.D.

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOV. RALPH MOORE 19 2010 PM ^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING If Under 1 Year If Under 24 Hrs. Funeral Social Security Number 6 Sex 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 📉 M 2 🗆 F Months Hours 1-M2th, 1928 WILMINGTON, NC **Director** 82 243-32-3761 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits ral", or items 23a or 28a-f s Examiner must be notified 1 🕅 Yes 2 □ No DC WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6423 - 2ND PLACE, N.W. 20012 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1X Yes 2 If Yes, Give Black, White, etc. 1 Never Married 2 Married þ within 72 hours after Maryland 21215-0036 1 Tes 2 No Specify "natural", Specify: BLACK Completed 3 Divorced 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic College (1-4 or 5+) YEARS Elementary/Seconday (0-12) RECREATION SUPERVISOR DC DEPT. OF RECREATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MAE OWENS GENERAL E. JACKSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAXINE H. JACKSON--WIFE 6423 - 2ND PLACE, N. W. WASH., DC 20012 Baltimore, 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 4 Donation 5 Other (Specify) LINCOLN CEMETERY 11-27-2010 BRENTWOOD, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PINCKNEY-SPANGLER FUNERAL HOME 524 - 8TH ST., N.E. WASH., DC 20002-5236 in 23a. Part 1. Enter the disease, or complications that caused the death, op not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) SEVERE CARDIOMYOPATHY Medical Due to (or as a consequence of) **Examiner** HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Exami and--transit that the death certificate be executed RENAL FAILURE that initiated events Due to (or as a consequence of) resulting in death) Last the burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year 2 🗌 No ed by the a 1 L Yes 2 L 9 D Unknown g 🗌 Unknown P.O. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Ninknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? Yes 2 4 N 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ပု 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the h 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year, 11-22-2010 D 0050063

Registrar

DHMH 17 Rev 7/2009

State

1500 FOREST GLEN ROAD SILVER SPRING, MD

30. Name and address of person who impleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MD

KANWALJIT NAGI
31. Date filed (Month, Day, Year)

NOV 2 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Donald Jenkins November 7:35 a.mM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital eonardtown St. Mary's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New Jersey Funeral 7. Age (In yrs. last birthday) 8. Date of Birth Days 1 X M 2 □ F Hours (Month, Day, Year) 05/20/1927 Director 83 Yrs 140-20-2375 Usual Residence of Decedent shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 X No Maryland Prince George's Riverdale Park 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20737 United States 5410 Riverdale Road ed other than "natural", or items event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 M Widowed 4 □ Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 8 Police Officer U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ other traumatic Myrtle Long Edward Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other tra 20745 7124 Leyte Drive, Oxon Hill, MD Chuck Jenkins/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Cre 11/30/2010 | Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Sean Aylesworth 20650 22955 Hollywood Road, Leonardtown, MD M01521 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Lung disease or condition Medical resulting in death) Due to (or as a con equence of): **Examiner** Pleuna Sequentially list conditions, Examiner Due to for as a nonsequence of) cause. Enter Underlying Cause (Disease or iinjury signed by the attending physician and be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Pes 2 L 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Cerebero vascular 1 Yes 2 No 3 Probably 4 Unknown Completed Dementia. 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No **Division of Vital** Be 26. Place of Death (Check only one) Hospital: Other: ၉ 1- Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred injury 1- Natural 5 Pendina 1 Yes 2 No 2 Accident Investigation within 24 hours after deatl To the Funeral Director. 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practiceers To the best of my knowledge, Seeth Consend at the time, Sate and Class, and due to the seaso(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D60888 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Rakhi Krishnan, M.D.

3 0 2010

当

egistrar's Signature

26840 Point Lookout Road, Leonardtown, MD

20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	State		artment of Health tificate of Death			0010	39026	
			Registrar 1. Decedent's Name (First, Middle, Last)	007	tineate or beatin		Reg. No	* U I U	3. Time of Death	
	Physicia		Lillyth Anne Jenso	en		Mont		9. Year 2010	2:30 A ^M	
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location		1	c. County of Death	2.30	
-	<i>}</i>		St. Mary's Hospital		Leonard	ltown		St. Ma	arv's	
	Funeral		1 □ M 2 🔀 F	(In yrs. last birthday)	If Under 1 Year If Under 1 Months Days Hours		of Birth th, Day, Year)	9. Birthp Count	lace (State or Foreign ry)	
	Director		N/A Usual Residence of Decedent	0 Yrs.	2		ber 29,	2010 Mar	yland	
	and show lat	P		10c. City, Town or Loc	cation			11	0d. Inside City Limits	
	Maryla 8a-f	Director	North Dakota Grand Forks		Emerado)			1 ☐ Yes 2 🖾 No	
	the la or 2 be no		10e. Street and Number		10f. Zip Code		10g. C	itizen of What Coun	try?	
	n with	Funeral	1732 Cedar Street N.E.		58228			USA		
	deatl	F	11. Marital Status 12. Was Decedent Ev Armed Forces?	. If	Vas Decedent of Hispanic C f Yes, specify Cuban, Mexic	origin? (Specify Yes o an, Puerto Rican, etc	or No- c.)	14. Race - America Black, White, e		
36	after al", o xami	d by	1 ☒ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ N 3 ☐ Widowed 4 ☐ Divorced Year or Dates	lo 1	☐ Yes 2 🖾 No Specif	fy:		Specify: Whit	e	
9	hours natura ical E	Completed	15. Decedent's Education		lent's Usual Occupation		16b. h	Kind of Business Inc	iustry	
218	in 72 e. nan "r	mc	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+	life D(kind of work done during mo O NOT use retired)	ost of working				
7	with ygien her th	ا به ا	0	1	Never Worked					
Maryland 21215-0036	e filec ntal H ed ot even	To B	17. Father's Name (First, Middle, Last)		18. Mot	ther's Name (First, M	liddle, Maiden	Surname)		
2	d Mer d Mer mark matic		Daniel Ryan Jensen 19a. Informant's Name/Relationship (Type, Print)	1		Cassandra				
Ma	2 sho th an 27 is traul	1		4	ng Address (Street and Num				ode)	
re,	f Heal		Daniel Ryan Jensen / Father 20a. Method of Disposition	20b. Place of Dispos		Date	20c. L	ocation - City or To	wn, State	
m ₀	age ent o	- 3	1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	1	natory or other place) an Crematory	November 29		exandria, V	irainia	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License		. Name and Address of Fac	ilityMatting1e	y - Gardin	er Funeral	Home, P.A.	
8		1	Michael Hardiner			P.O. Box :	270, Leo	nardtown, M	D 20650	
			23a. Part/1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	the death. Do not ente	er the mode of dying, such a	as cardiac or respirat	ory arrest,		Approximate Interval Between	
	Physician/	1 -	Immediate Cause (Final disease or condition		turity			36	Onset and Death	
	Medical Examiner		R	consequence of):)	1		,	,	
		er	Sequentially list conditions, D.	consequence of):	ruix (Mater	WAL)		r	dairs	
	ted Insit	amin	r fany, leading to immediate cause. Enter Underlying Cause (Disease or linjury							
	execu in and ial-tra	Exa	that initiated events resulting in death) Last C. Due to (or as a	consequence of):						
,60	e be (dical Examiner	d							
876	tificat ng ph e as th		IF FEMALE:				1			
9 X	th cer ttendi or use	ian/	23b. Was decedent pregnant 23c. If yes, outcome o	Petal death 3			Ť	23d. Date of deliver	ry Day Year	
Bo	e dea the a hed f	Physician/M	1	time of death 5 L	Other (specify)			WORK	buy .ca.	
P.O. Box 687	hat th ed by detac	y Ph	Part II. Other significant conditions contributing to death bu	t not resulting in the u	nderlying cause given in Pa	rt I. 23e.	Did tobacco	use contribute to th	e cause of death?	
S, I	uires t sign Id be	d by					1 🗆 Yes 2	□ No 3 □ Prob	oably 4 N Unknown	
oro	v requ	olete				24a	. Was an	24b. Were autop	sy findings available	
3ec	he lav te hav age 2	Completed					autopsy performed? Yes 2,000 N	death?	npletion of cause of	
a	ian: T irtifica stor, p	Be C	25. Was case referred to medical examiner?		26. Place of De	eath (Check only one		_		
ξ	hysic his ce Il dire	မ	1 ☐ Yes 2 No Hospital: 1 Inpatier	nt 2 ER/Outpatien		Nursing Home 5	Residence	6 Other (Specify)		
וסנ	ling P	Certificate:	27. Manner of Death 1 ★ atural 5 Pending 28a. Date of injury (Month, Day,	/ 28b. Time of injury	work?	_	cribe how inju	ry occurred		
Sior	death death ctor: /	tific	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of Injur	y - At home, farm, stre	M 1 ☐ Yes 2		tion (Street or	nd Number or Rural	Route Number	
Division of Vital Records,	al or A after Direct		4 ☐ Homicide determined 206. Frace of flight building, etc.		,,,		or Town, State		ricato riambol,	
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of m	ny knowledge, death o	occured at the time, date an	d place, and due to	the cause(s) a	nd manner as state	d.	
	the Hi in 24 the Fi	Med	(Check 2 ☐ Medical Examiner: On the basis of exaction only one) 3 ☐ Certifying Nurse Practioner: To the basis of exaction only one)							
	To the within 2 To the comple		29b. Signature and title of certifier		29c. License number		29d. Da	ate signed (Month, L	Day, Year)	
			of the wheel		D50619	ž	10/	30/9010		
0	pme		30. Name and address of person who completed cause of de	1. 1	Street Su	de A law	ode Ll	. Mn a	20650	
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar		3118635 30	IN JE LES	mrd+Du	7"U 4	-Ues (/	
	Registra	ar	NOV 3 0 2010 Jane	wa B.	park					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 27 2010 Mary Keith 2:54 РΜ Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Memorial Hospital Frederick . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Funeral 1 🗆 M 2 🖾 F 91 Days Hours ov 27, 1919 217-32-1239 Maryland Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a State 10h County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Carrol1 Keymar 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21757 USA Funeral 851 FSK Highway 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. "natural", or 1 Never Married 2 Married þ ☐ Yes 2 **X X**No Yes, Give Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify Specify Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) National Institutes other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha of Health Animal caretaker 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e Nettie Harris should be 1 Oliver Stevens 19a. Informant's Name/Relationship (Type, Print)

19a. Informant's Name/Relationship (Type, Print)

Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynette A. Wolfe -851 FSK Highway, Keymar, Maryland In-Iaw 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12-2-2010 Parklawn Cemetery Rockville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 21702 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIN Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner remal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Month Year Day Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an directe this certificate has autopsy page 1 Yes 2 No Clusho'dim funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🗓 😽 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? iniury 1 Natural 5 Pending s after death. Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11-28-10 MD Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Ihomas

32. Regist ar's Signature

Shah

31. Date filed (Month, Day, Year)

656

Frederick MD 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 39028 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WOVEN 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death 405 restertown 72 If Under 24 Hrs. If Under 1 Year Social Security Number 6. Sex . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Months 163-34-7716 10/03/1941 Delaware Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No KENT ROCK HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5894 COTTAGE AVENUE USA 21661 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Specify: Specify: 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) i.e. CHESTER RIVER Elementary/Secondary (0-12) College (1-4or 5+) 10 UNIT CLERK MANOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Alphin Betty Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip Boulter Sr. - Husband 5894 COTTAGE AVENUE ROCK HALL, MARYLAND 21661 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 I Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WESLEY CHAPEL 12/02/2010 ROCK HALL, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 enter the mode of dving such as confine such as con HELFENBEIN & NEWNAM FUNERAL HOME Thert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final - 11 matrata

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be neathfund anonce.

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

þ

Completed

Be

2

MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriar-transit physician and the burial-transi attending pl s been signe should be c

Division of Vital Records, P.O. Box 68760,

	resulting in death)	Due to (or as a consequence of):	Transcrans	14 monne
Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a consequence of): C. — Due to (or as a consequence of):		
Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of de Month	Divery Day Year
Completed by Pr		contributing to death but not resulting in the underlying cause given in Part I. D & Peripheral arterial Discesse.	23e. Did tobacco use contribute to the second secon	
Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: Other:	performed? death? 1 □ Yes 2 ☑ No 1 □ Yes th (Check only one)	s 2 No
ertification: 10	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	2 EH/Outpatient 3 DOA A Nursing Ho 28a. Date of Injury (Month, Day, Year) 1 Yes 2 No	ome 5 ☐ Residence 6 ☐ Other (Spe 28d. Describe how injury occurred	ecify)
Certific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or R City or Town, State)	
dical	29a. Certifier (Check only one) 1 ✓ Certifying Ph 2 ☐ Medical Exam	iysician: To the best of my knowledge, death occurred at the time, date and place, niner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated	, and due to the cause(s) and manner a red at the time, date and place, and due	s stated. e to the cause(s)

Registrar DHMH 17 Rev 1/2001

State

Rm

within 24 hours a
To the Funeral I
completely filled

29b. Signature and title of certifier

31. Date filed (Month

14/16llhum, MD

WUN,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

415 Washington Ave,

29c. License number

Chestertown, MD

D21313

21620

29d. Date signed (Month, Day, Year)

11/29/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month NOVEMBER CHARLES KINNA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number if Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1XXM 2 Days Min. April 22, 1920 Maryland 90 219-12-0384 Director Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits ems 23a or 28a-f sho r must be notified a Director Yes 2 No Maryland Frederick Jefferson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3885 Shadywood Drive 21755 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: white "natural", 3 ₺ Widowed 4 □ Divorced Completed Year or Dates M-dical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental H 2 Dewey Kinna Jane Ramsburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Kinna, Jr. - son 5034 Teen Barnes Road, Frederick, Maryland Health a 21703 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State partment of Foortant: If ite Date cemetery, crematory or other place)
Mt. Olivet Cemetery 1 X Burial 2 Cremation 3 Removal from State Important: 11-27-2010 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Aspiration Physician/ days Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial fibrillation Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 I DOA 24 hours after death. Funeral Director: After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending thin 24 hours after death. 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Brunswick

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:01 PM Betty Blue Knott November 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Prince Frederick Calvert Memorial Hospital 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Country) West Virginia Months Hours Min. (Month, Day, Year, Director 220-34-6441 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 X No Lothian Maryland Anne Arundel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 493 Keith Road 20711 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify: White Completed 3 X Widowed 4 ☐ Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of and 2 should be fill of Health and Mental ၉ Sarah Dainty Losh Floyd Moats 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mechanicsville, MD 20659 Barbara J. Nelson / Daughter 39260 Wigeon P1, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State November 29, 4 Donation 5 Other (Specify) 2010 Leonardtown, Maryland Charles Memorial Gardens Signature of Funeral Service Lice 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 lara 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Atherosclerotic Immediate Cause (Final Physician/ Cardio Vasular disease disease or condition Medical resulting in death) Examiner Vaccular chiseuse Hypertensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and -transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year n signed by the an Id be detached fo 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Aspiration Records, Pneumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Urinary ate has bage 2 s performed 1 Yes 2 No Anaemia. this certificate Yes 2 No of Vital after death.

Director: After this certific
In by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🛂 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide work? 5 Pending Division Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

5 RMe

Registrar

State

31. Date filed (Month, Day,

ORIGINAL

Churchton

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 2 9 2010

D 50653

C.

Deale

SURANA

GYAN

Road

11-24-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Nov. Physician/ 1.9 ay 2010 2315 hrs.M George Kenneth Lipscomb Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George Prince George's Hospital Center Cheverly, Maryland If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Nov. 10, 1951 Months Hours North Carolina Director 239-86-3959 59 Usual Residence of Decedent or 28a-f show e notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Tes 2 No Maryland Prince George ${ t Mitchellville}$ 10e. Street and Numbe 10f Zin Code ò 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 207616 USA 11203 Lake Overlook Place Was Deceuent Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify Specify: Black 3 Widowed 4 Divorced Completed er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working age 1 and 2 should be filed within 7 ent of Health and Mental Hygiene.

nt: If item 27 is marked other than by or other traumatic event, the ME life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Case Manager D.C. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ George Kenneth Lipscomb Sr. Clara Cotten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Lipscomb Reddish-Sister 706 Grandview Drive Durham, North Carolina 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or **Beechwood Cemetery** Nov.27,2010 Durham, North Carolina 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature Funeral Service Licens R.N. Horton Company Morticians, Ind.,. Street N.W. Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 'Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? as been signed by the atte Day Year 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an after death.

Director: After this certificate has I perform 2 🗌 No Yes 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Tyes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Medical 29a. Certifier 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 To the F 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D41405 November 21, 2010

Registrar
DHMH 17 Rev 7/2009

State

M.D.; 3001 Hospital Drive; Cheverly, Maryland 20785

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Norman W. Allen;

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Peggy D. Lee Nov. 17, 2010 Year 6:30a M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fox Chase Nursing Home Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 487-28-6595 1 □ M 2 🔀 F Hours Feb. 10 86 Ok Tahoma า๊924 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits D.C. Washington 1 HYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3060 16th Street NW #201 20009 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 X Never Married 2 Married Yes 2 No Black, White, etc. If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced White Specify: Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Legal Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Everett N. Lee Icol L.Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Cuviello/Son 18131 Marksman Circle #102 Olney, MD. 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate of Heaven 11/24/2010 Silver Spring, MD 4 Donation 5 Other (Specify) 型 Note 中 Pod Ds. R T NALDI FUNERAL SERVICE, P.A. 0

Physician/ Medical **Examiner**

Physician/

Medical

10a. State

Director

by Funeral

Completed

Be

ည

Examiner

Funeral

Director

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlal-transit and -transit physician a the burialsigned by the

Division of Vital Records, P.O. Box 68760

	wy de No.	will,	9241	Columbia	Blvd.Silv	er Spr	ing,Md2091		
	23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one Immediate Cause (Final disease or condition	ications that caused the death. Do not e cause on each line. Lung Cancer	enter the mode	e of dying, such as cardi	iac or respiratory arrest,		Approximate Interval Between Onset and Death		
	resulting in death)	Due to (or as a consequence of):					ono.		
miner	Sequentially list conditions, if any leading to in rediate cause. Enter Underlying Cause (Disease or linjury	Due to for sels oursequence of:	1						
edical Exa	that initiated events resulting in death) Last	Due to (or as a consequence of):							
Physician/Medical Examiner	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (specify) Month								
ompleted by P	Part II. Other significant conditions con hypertension, c	tributing to death but not resulting in the hronic kidney of			1		o the cause of death? Probably 4 🗆 Unknown		
3					24a. Was an autopsy performed?	prior to	utopsy findings available completion of cause of		
De	25. Was case referred to medical examiner?			26. Place of Death (Ch	neck only one)				
2	TE Yes 2 11 No	ospital: 1	tient 3 🗆 DO	Other: 4 🔀 Nursing	Home 5 Residence	6 Other (Spec	cifv)		
Eate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of injury (Month, Day, Year) 28b. Time injury		c. Injury at work? 1 🗆 Yes 2 🗆 No	28d. Describe how inju				
a Cert	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	Se. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Str. City or Town)						
ובחוכ	(Check 2 12 Medical Examine	ian: To the best of my knowledge, deater: On the basis of examination and/or inv	estigation, in m	v opinion, death occurred	d at the time, date and place	e and due to the	ated. cause(s) and manner state		

29c. License number

D28656

15245 Shady Grove Road #130 Rockville, Md 20850

29d. Date signed (Month, Day, Year) Nov.19,2010

DHMH 17 Rev 7/2009

State

Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, Year

Ravi Passi M.D.

NOV 24 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month HARLOTTE ANGER 27 AM 01 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sanctuary at Holy Cross Montgomery Burtonsville Social Security Number . Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Months Davs Hours Min June 9 Day, Year) 069-28-5932 83 Yrs. **Director** Germany Usual Residence of Decedent a or 28a-f show be notified at 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 5225 Pooks Hill Road, USA #402 20814 11. Marital Status 12 Was Decedent Ever in LLS 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? ρ 1 Never Married 2 ☐ Married Maryland 21215-0036 Yes. Give 1 Yes 2 No Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Administrator Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elton F. Norman/Executor 8720 Georgia Avenue, #906, Silver Spring, MD 20910 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ŏ ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Department of Important: If any injury or Noy 24 Metropolitan Crematory 4 Donation 5 Other (Specify) Al<u>exandria</u>, VA Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring.MD 20901 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE . If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Year Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy Yes 1 Yes the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work 1 🗌 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and ti∤le of certifier 29d. Date signed (Month, Day, Year, 23 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day,

Year)

2835

HAMI

32 Registrar's Signat⊌re

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month WILLIS LUFFMAN 2010 November 23:10 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Poninsula Regional Medical Salisb icomico cente If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 9. Birthplace (State or Foreign Sex 1 XM 2 □ F Days Hours SEPT. 29,1945 NORTH CAROLINA Months Min. 221-28-7621 Director 65 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Me-ical Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND WICOMICO PITTSVILLE 1 ☐ Yes 2 🕅 No 10e, Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 6676 FRIENDSHIP ROAD 21850 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Maryland 21215-0036 þ 1 Never Married 2 Married WHITE 1 ☐ Yes 2 X No Specify: If Yes Give 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and 2 should be filed within Health and Mental Hygiene. tem 27 is marked other than DELIVERY PERSON NEWSPAPER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BELMA GREER JAMES WALTER LUFFMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 WINDER STREET, SALISBURY, MD 21801 DWAYNE LUFFMAN/SON permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other t other i Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burlal 2 XCremation 3 ☐ Removal from State cemetery, crematory or other place) CREMATORY OF DELMARVA 11/23/2010 DELMAR, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) Si nature of Funeral Service Acen 22. Name and Address of Facility ZELLER FUNERAL HOME, P. O. BOX 3171 1212 OLD OCEAN CITY ROAD, SALISBURY MD 21802 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician pindle Cell Carelno disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events the burial-tran Due to (or as a consequence of) resulting in death) Last been signed by the attending physiclan should be detached for use as the hirial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 5 Other (specify) Month Pregnant at time of death Day Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ robably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performe 1 Yes 2 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဂ္ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA funeral Manner of Death 28a. Date of injury Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural (Month, Day, Year) 5 Pending 1 Tes 2 🗌 No Investigation within 24 hours after death To the Funeral Director: the Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. **Signaty**

MO

E

100

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

myeller

32. Registrar's Signature

Sohrum

NOV 29

31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

Stress

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Lucrecia Carmen Matus 9:38 November 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 9008 Breezewood Terrace, Apt. #302 Greenbelt 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. g. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F 69 Director 577-78-1930 Granada. Nicaragua February Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Maryland Prince George's Greenbelt 1 X Yes 2 No 10f, Zip Code 10g. Citizen of What Country? Funeral 9008 Breezewood Terrace, Apt. #302 20770 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 🛭 Yes 2 🗆 No Specify: Nicaraguan Specify: Hispanic 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chef Restaurant should be filed with and Mental Hygien is marked other th 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carlos Romero Maria Chavarria permit, Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ana P. Davila / Daughter 9008 Breezewood Terrace, Apt. #302, Greenbelt, MD 20770 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🛭 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 11/29/10 Alexandria, Virginia Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 RAY Ragar 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Pancreas Cancer Medical resulting in death) Due to (or as a consequence of): **Examiner** Metastatic Liver Disease Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death Other (specify) 1 | Yes 2 | 9 | Unknown g Unknown signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 \square Yes 2 \boxtimes No 3 \square Probably 4 \square Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sate has l page 2 s autopsy performed' 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 1 24 hours after death. **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 2 🔀 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how Injury occurred eral Director: After filled in by the funer X Natural work? 5 Pending 2 \square No Investigation Accident Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

P.O. Box 68760

Records,

State Registrar 29b. Signature and title of certific

31. Date filed (Menth, Day, Year)

30. Name and address of person who completed cause of peath (Item 23a) (Type, Print)

Dr. Sassan Taghizadeh

2010

1160 Varnum Street, NE #115

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State of Maryland				nd Mental Hy	giene	00000		
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	Certificate of Death 2. Date of Death 3 Time of Death						
	Physicia		Sidney Keith Miller				Month Nov.	Day Year	3. Time of Death		
~	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of D		4c. County of Dea			
- 200	<i>!</i>		PENISSULA REGIONAL MEDIANE CON	He		MISHI	11	1 . /	2001/00		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las		If Under 1 Year Months Days		Hrs. 8. Date of Bir	th 9. Bi	rthplace (State or Foreign		
40	Director		219-62-9159 55 Usual Residence of Decedent	Yrs.	Montrio Bayo	Tiodis	March March	24, 1955 Ma	ryland		
	and show	5		Town or Loc	ation				10d. Inside City Limits		
	faryla Ba-f s tified	Director	Maryland Somerset Pri	ncess	Anno				1 Yes 2 No		
	the N	ā	10e. Street and Number	neess	10f. Zip Code			10g. Citizen of What C	ountry?		
	s 23g	Funeral	9952 Arden Station Road		21853			US	·		
	death item ner n	Ē	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	as Decedent of His Yes, specify Cubar	spanic Origin?	(Specify Yes or No-	14. Race - Ame			
36	after al", or xami	db	1 Never Married 2 Married 1 Yes 2 No		☐ Yes 2 No		aos to Filoani, oto.j	Black, White			
9	nours latura ical E	Completed	15. Decedent's Education	16a Dacad	ent's Usual Occupa			Specify: Whi			
215	n 72 ł e. an "n Medi	ם	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give k	ind of work done do NOT use retired)	uring most of	working	16b. Kind of Business	Industry		
21	withi giene er th		12	Car	Dealer			Transport	ation		
nd	e filed tal Hy ed oth	To Be	17. Father's Name (First, Middle, Last)				Name (First, Middle,	Maiden Surname)			
yla	uld be I Men narke natic	-	Sidney Francis Miller			Cla	ra Lewis				
Maryland 21215-0036	2 sho th and 7 is r		19a. Informant's Name/Relationship (Type, Print)					r, City or Town, State, Zi	· ·		
ē,	and Heal tem (Julie Miller, Wife 20a. Method of Disposition		Arden Sta	ation H		ncess Anne,			
υOL	age 1		1 Burial 2 Cremation 3 Removal from State Cer	netery, crem	atory or other place Cremator		Date	20c, Location - City or	·		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee				./24/10	Salisbury	, Maryland		
m	permi Depar Impor any in	1	Cam 7 11 / M00295	1	1672 Some	reat A	linman Fun	eral Home	e, Md. 21853		
			23a Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not enter	the mode of dying	, such as card	liac or respiratory arr	est,	Approximate		
	nysician/	1 54		01	C				Interval Between Onset and Death		
	Medical Examiner		Mediate Cause (Final sease or condition resulting in death) a. Due to (or as a consequent of the consequence o	nce of):	a con				12,0000		
		-	Sequentially list conditions, b.								
	sit sit	Examiner	ff any, leading to immediate cause. Enter Underlying Cause (Disease or inniur)	ice oi).							
	xecut and	Exa	that initiated events resulting in death) Last C. Due to (or as a consequent of the		100						
09	icate be executed physician and s the burial-transit	edical	d								
876	ificate ig phy as the	Med	IF FERRAL F.								
× 68	h cert tendin r use	au/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnanc 1 ☐ Live Birth 2 ☐ Fetal of		Ectonic pregnancy			23d. Date of del	ivery		
P.O. Box	death he att	Physician/M	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of dea 9 Unknown 9 Unknown	ith 5	Other (specify)			Month	Day Year		
o.	at the d by t letach		Part II. Other significant conditions contributing to death but not result:	ing in the un	derlying cause give	n in Dort I					
s,	res th signe d be c	g P	guille double but not rough	ing in the un	acitying cause give	iriir Fait I,		bacco use contribute to ′es 2 ⅪNo 3 ☐ Pr			
ğ	requi been shoulk	ete									
Vital Records,	e has	Completed					24a. Was a autop: perfor	sy prior to d	copsy findings available completion of cause of		
工 元	an: The tifficat for, pa	Ф	25. Was case referred to medical		26 Pino	o of Dooth (Cl	1 Yes	2 No 1 ☐ Yes	2 🗆 No		
Ĭ	ysicia is cer direct	10 B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 Fe					200 6 T Other (Const	Z.1		
27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. De								ow injury occurred	TY)		
0	tendil leath. or: Al	<u> </u>	1 Natural 5 □ Pending (Month, Day, Year) 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	y	M 1 ☐ Ye	es 2 🗆 No					
DIVISION	or At after of Direct in by	Certificate:	4 Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, stree	t, factory, office		28f. Location (St City or Town	reet and Number or Run n, State)	al Route Number,		
ָ ב	spital ours cours eral l		29a. Certifier 1 Certifying Physician: To the best of my knowled		numeral add to the con-		1				
:	n 24 h	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowleddy only one) 3 Certifying Nurse Practioner: To the best of my knowleddy only one)	id/or investio	ation, in my opinion	death occurre	ad at the time date on	d place and due to the e	augo(a) and manner stated		
Ī	Nithii To th		29b. Signature and litle of certifier	- Townsago, ac	29c. License n			9d. Date signed (Month)			
	100		At / m.o		03	0690	_	Nov. M.			
	TCA TCA		30. Name and address of person who completed cause of death (Item 23	a) (Type, Prir	nt)						
	State		31. Date filed (Month, Day, Year) 32. Regisfrar's Signature	100 6	s. Corrol	1 5%.	, Joloss	no, mo	21801		
	Registrai		Some 5 El, MARTIN, M.O., B1. Date filed (Month, Day, Year) NUV 29 2010 Census	1. 14	back						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ George Thomas Myers 2010 December PM Medical 7:05 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth g. Birthplace (State or Foreign Days 219-07-8825 1 **X** M 2 □ F Months Hours 91 Director Yrs December 11, 1918 Maryland Usual Residence of Decedent show 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f si any injury or other traumatic event, the Medical Examiner must be notified. Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 202 Grove Boulevard 21701 United States of America 12. Was Decedent Ever in U.S. Armed Forces?

1 12 Yes 2 \(\subseteq \) No 1942-11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ģ 1 Never Married 2 X Married Black, White, etc. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Divorced 4 Divorced White Completed Specify: 1945 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Representative Industrial Brush Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Worthington Myers Sally Pearl Delphey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 Grove Boulevard, Frederick, Maryland 21701 Rose Marie Myers / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Olivet Cemetery Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State December 6, 4 Donation 5 Other (Specify) Frederick, Maryland 2010 Keeney & Bastord P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BRUSIS Physician -MON disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliven 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Day 1 Yes 2 9 Unknown 2 🗆 No Year the 9 Unknown Division of Vital Records, P.O. been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No 24a. Was an has autopsy performed Yes 2 this certificate To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 X No 은 Other: 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pendina Accident Suicide 1 ☐ Yes 2 ☐ No Investigation 3 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year)

State Registrar DW6/

Date filed (Month,

DEC 10

1 DUES

FRED BRICK

#204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3-81510m

Mis

Dark

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Cori Jo Marshal	2	1- For State Registrar	Si	tate of Maryla		epartment o <i>Certificate o</i>		d Mental H	-	Reg. No.	2010	39038
Physici Medical Exam		Decedent's Name (First, Middle,Last)							2. Date of Death 3. Tim			3. Time of Death
\subseteq_j		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location or						Location of Dea		4c.	County of Dea	ath
Funeral		416 W.B. S 5. Social Security N		6. Sex	7. Age (In	yrs. last birthday)	Brunswick If Under 1 Yea	r If Under 24H	rs. 8. Date of B		rederick	Birthplace (State or
Director		524-75-3	399	1 M 2 X F	2	.7 Yr	Months Day	s Hours Mi	^{n.} 7/5/1	983		eign Country) CO
any	tor	Usual Residence o 10a. State	f Decedent 10b. County		10c	. City, Town or Loca	tion					10d. Inside City Limits
Maryland 28a-f show d at once.		MD		derick		Brunswi				1 X Yes 2 No		
he Mary or 28a	Director	10e. Street and Nu		Street			10f. Zip Code 2171	6			en of What Co	ountry?
h with t ems 23a	Funeral	11. Marital Status		12. Was Dec			as Decedent of His res, specify Cuban	spanic Origin? (S				erican Indian, Black,
her deat ", or its		1 Never Marrie 3 Widowed		1 Yes	2 X		Yes 2 X No		o racan, etc.)	s	Specify: Wh	ita
hours af	ed by	15. Decedent's Ed	ducation (Spe	or Dates: ecify only highest gra	de complete		nt's Usual Occupat	ion (Give kind of			nd of Busines	
Imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items 23a or 28a-f shoor or other traumatic event, the Medical Examiner must be notified at once.	ro Be Completed	Elementary/Second 12	ondary (0-12)	College (I-4 or 5+)	House	_	501101 00010		Н	iomemak	er
21215-0036 und be filed within 7 Mental Hygiene. marked other than		17. Father's Name						1B.Mother's Nam	•		,	<u> </u>
212' 212' ould be I Mental marke		Charles 19a. Informant's Na		d Banks Jr ship (Type, Print)	•	19b. Mailin	g Address (Stree		ssa Kay Rural Route Nu			ite, Zip Code)
MD and 2 sho salth and em 27 is raumatic		Jason Ma 20a. Method of Disp	rshall	, Husband		416 W	lest B St		runswick		21716 ocation - City	
Baltimore, MD 21215-00 permit. Pages I and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the M		1 Burial 2	Cremation	n 3 Removal fr		crematory or ot Hagenstown	her place)	·]	6/2010		perstown	,
Saltin rmit. P epartne oportar jury or	1	4 Donation 5 21. Signature of Fu					Name and Address		3/2010	l no	ELSUMI	thD
Physician		23a. Part I, Enter th	e disease, or	complications that c	aused the c		hn T Willia he mode of dying,					21716 Approximate Interval
/Medical Examiner										Between Onset and Death		
	-	Sequentially list conditions, b.										
	edical Examiner	cause. Enter Underlying Cause (Dispose or injury that initiated c. (Due to (or as a consequence of):										
50, te be executed ysician and burial - transit	EX	events resulting in death) Last Due to (or as a consequence of): d										
60, e be exe ysician burial -		W UNPENDED		AMENDED		,pt.II,27	per me	g911 1-	28-11 v			
6876 ertificat ding ph	ian/N	IF FEMALE: 23b. Was decedent p past 12 months		I Live D	irth	2 Fe	tal death 3	Ectopic pregn	ancy		Date of delive Month	Day Year
Box 6876 re death certificate the attending phy red for use as the	Physician/M	1 ✓ Yes 2 N	lo 9 Unk	known 9 V Unkno	ant at timė wn	ordeath 5 Ot	her (Specify)			1 _		
Vital Records, P.O. Box 6876 vician: The law requires that the death certificat his certificate has been signed by the attending phidirector, page 2 should be detached for use as the	b P	Part II. Other signif		ions contributing to	death but	not resulting in the u	inderlying cause g	iven in Part I.				o the cause of death?
Division of Vital Records, P.O. talor Attending Physician: The law requires that th rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deauch	Completed		.cy		.				24a. Was	an	24b. Were a	autopsy findings available
Reco	ошо								autop perfo 1 V Yes	rmed?	prior to death?	
ital Rec ician: The s certificate rector, page	Be	25. Was case referre		Hospital:	npatient 2	ER/Outpatient		of Death (Check				
J Of V sing Phys After thi funeral di	n: To	27. Manner of Death	No No	2Ba. Date		2Bb. Time of I		y at Work?	ng Home 5		ce 6 🗹 Othe	er: Scene
ivision or Attendi after death. Director: I in by the fi	catio	1 X Natural 2 Accident	5 Pend	ling stigation		At home form at		es 2 No	0001	01		
DIVI pital or ours afte	Certification	3 Suicide 4 Homicide		d not be mined (Specify)	or injury -	At home, farm, stree	et, factory, office bt	uliding, etc.	or Town, S		Number or R	tural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical			nysician: To the bes miner:On the basis of and manner st	f examinati							
H × H 3	Ĭ											
	-	(NUM) 30. Name and addre	ess of person	who completed caus		(Item 23a)	U.C.N	1.L.		Dece	mber 3, 20	710
5		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201										
Sta Regist		31. Date filed (Mont)	EC Year	2010 32. 8	gistrar's Sig	gnature (ile!			OGME	•	
										40 W 1816	•	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ada November 23. 2010 Ruth McClair 8:45 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Mount Airy Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Days Feb. 4. 1927 Months Hours Min. Director 022-20-3320 Massachusetts 83 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State within 72 hours after death with the Maryland 10b Count 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 222 Broadway Street, Apt. 203 21701 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or ite 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Secretary United States Navy ge 1 and 2 should be filed wit nt of Health and Mental Hygie t: If item 27 is marked other? Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Smith Myrtle Duncan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222 Broadway St., Apt. 203 Frederick, MD 21701 Alexander McClair / Husband 20a Method of Disposition 20b. Place of Disposition (Name of Nov. Date 4. 20c. Location - City or Town, State Page 1 permit. Page
Department o
Important: If
any injury or
once. ö 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Resthaven Crematory 2010 Frederick, Maryland 22. Name and Address of Facility Resthaven Funeral Services, 9501 Catoctin Mountain Hwy. 21. Signature of Emeral Se Skkot Cody P.A. Frederick, MD 21701 23a. Part 1. Enter the diseas shock, or heart failure. Immediate Cause (Final complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ist only one cause on each line. Interval Between Physician/ Tal tus 0 disease or c - dition resulting in death) Me seal Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury Due to (or se a consequence or): attending physician and for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Day Year 2 X No the a 9 Unknown Unknown 9 signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ has been signed to the second Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy page performed? Yes 2 No certificate 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 X No ျ 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA Hespice It ous After this 4 Nursing Home 5 Residence 6 N Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? ☐ Accident ☐ Suicide 1 Yes 2 No neral Director: / Investigation 3 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar only one)

Elham4

31. Date filed (Month, Dat

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Eskonder

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

Frederick

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MORROW CAROLYN NOV Month 18 2010 12:05 a M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGES CLINTON CLINTON NURSING HOME If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 T7 A Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours Dec 18, 1934 VA Director 227-42-9628 75 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2X No New Castle Wilmington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19802 USA 2610 Jessup St. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 Widowed 4 Divorced Black Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur jury or other traumatic event, the Medical] 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Bank Teller Banking yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Maria Pullum Herman Huntley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2610 Jessup St. Wilmington, DE Roy T. Morrow - Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 12/2/2010 Haven Crematory Chestertownship, PA Marshald Marchity Funeral Home of Maryland Suitland, MD 20746 Suitland Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Cardiac Arrythmia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or iinjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Bipolar that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death 2 🔀 No 1 ☐ Yes 2 12 g ☐ Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available 24a. Was an cate has prior to completion of cause of death? performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate is completed filled in by the funeral director, page 2 No 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: Certificate: To 2 🗓 No 4 Mursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

only one) 29b. Signature and title of certifier

Danac

Khosrow Davachi, MD

31. Date filed (Month, Day, Year)

NOV 2 4 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7801 Old BRanch Ave.

MO

32. Registrar's Signature

29c. License number

Clinton, MD. 20735

11/22/2010

D0025640

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U | U State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month HENRY BRTSCO MCCALL 2010 Nov 8:34 a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Southern Maryland Hospital Clinton Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, NoV 29) Birthplace (State or Foreign Country)
 NC 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 1x M 2 D F Director 81 NC241-30-5870 Usual Residence of Deceder 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director DC 1 X Yes 2 ☐ No Washington ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20020 3200 Alabama Ave. USA items death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō ģ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give and Mental Hygiene. is marked other than "natural", Specify Completed 3 🛮 Widowed 4 🗆 Divorced Black Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed 12th Home Improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Oscar McCall Flora McEachin Page 1 and 2 should ment of Health and M 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Carolyn McCall Awkard-Daughter 803 Festival Ct. Mitchellville, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 11-29-2010 Lincoln Memorial Suitland, MD Marshall-March Funeral Home of Maryland Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Anteriosclevotic disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** rebra Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown been signed by the should be detached ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has all director, page 2 autopsy performed Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 \sum Yes 2 **N**O 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) neral Director: After the filled in by the funera 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Within 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certific completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who MC Call 11701 Cluingsh 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ S. McCallister November T8, 2010 Daisv 11:55P. Medical 4b. City, Town, or Location of Death **Timonium** 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore Examiner Stella Maris, Inc. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7 Age (In vrs. last birthday) 8 Date of Birth Funeral Days AU 13 1927 West Wirginia 1 - M 2 - XF 83 236-36-9771 Director Usual Residence of Decedent 10a, State 10b County 10d. Inside City Limits 10c. City, Town or Location death with the Maryland Director ems 23a or 28a-f sh r must be notified a Maryland Prince George's Beltsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20705 United States 4706 Olympia Avenue ral", or items 2 Examiner mus 11:55 p.m. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify White Specify than "natural" 3X Widowed 4 □ Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natur ury or other traumatic event, the Medical I ury or other traumatic event, the Medical I 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Volkswagon of America Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Walter Smith Melinda Nora Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4600 Maple Avenue Halethorpe, Maryland 21227 Tanya Young -daughter Department of Health Important: If item 2: any injury or other t NOVEMBER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Union Cemetery 1 X Burial 2 Cremation 3 Removal from State 11/23/2010 Burtonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Bonald Cores Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition CEREBROVASCULAR ACCIDENT **Medical** resulting in death) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? DAISY McCALLISTER for Month Year Day Pregnant at time of death 2 X No page 2 should be detached g 🗌 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy Yes 2 X No 1 Tes within 24 hours after death.

To the Funeral Director: After this certification of the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) work?
1 \(\sum \) Yes 2 \(\sum \) No injury 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 🛣 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29b. Signature and

Registrar
DHMH 17 Rev 7/2009

State

JACKIE JONES

31. Date filed (Month, Day, Year)

2300 DULANEY VALLEY RD

TIMONIUM, MD 21093

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 39043 Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Miedzinski Hannah Elizabeth 2010 Medical November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Nursing Center Leonardtown St. Mary's Social Security Number 6 Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
Maryland Days Hours (Month, Day, Year) 03/14/1921 1 M 2 K F Min Director 89 219-12-3483 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 3a or 28a-f sl t be notified Maryland St. Mary's Lexington Park 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21645 Columbia Street 20653 USA "natural", or items and 2 should be filed within 72 hours after death v Health and Mental Hygiene. Tem 27 is marked other than "natural", or items ther traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Completed 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John David Stone Lucille Sophia Goldsborough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 21645 Columbia St., Lexington Park, MD 20653 Harry Wheatley/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Page 1 a
Department of F
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. John's Catholic 11/27/2010 Hollywood, MD Signature of Foneral Service Aconsee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield 22955 Hollywood Rd., Leonardtown, MD 20650 Jr. M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate on each line Immediate Cause (Final disease or condition Onset and Death Physician/ 1am Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the attending physician and hed for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: es, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 5 Other (specify) Day 9 Unknown P.O. After this certificate has been signed by 'attenthis certor, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death
1 Natural
2 Accident Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 5 Pending injury 2 No Investigation 1 Yes within 24 hours after death

To the Funeral Director: completed filled in by the: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatule and title of certific 29d. Date signed (Month, Day, Year)

Oph

DHMH 17 Rev 7/2009

State

Registrar

arke

25365 Point Lookout Rd., Leonardtown, MD 20650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

William Boyd, II, M.D.

NOV 30

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 11-100-2010 Lois M. Neil Physician/ 18:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Forestville 1705 Ritchie Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 03-13 1 □ M 2 🛣 F Months Hours 565-20-3508 91 919 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Forestville MD Prince George Is 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 1705 Ritchie Road 20747 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White Completed 3 Xidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 1 - 4 (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev မ Edith Riggs Samuel Wesley Irwin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1649 Walter Court, Colton, CA 92324 Barbara Orr-Willey/daugh. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cem. 11-16-2010 Suitland, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signatur of Funeral Service Licenses 20746 Cedar Hill FH,4111 PA Ave., Suitland, 23a Part 1 Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy Yes 2 X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐Xio 1 Inpatient 2 ER/Outpatient 3 DOA မူ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marrier as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of cer 29d. Date signed (Month, Day, Year)

State Registrar 9200 Basil Ct., Suite 200, Largo, MD 20774

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Iyan Zama,

31. Date filed (Month, Day, Year)

NOV 2 9 2010

MD

strar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Harold Robert Ney 2010 5:50 November Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Cecil 113 West Thomson Drive E1kton If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours (Month, Day, Year) Country) 1 🕅 M 2 🗆 F Yrs. Director PΔ 98-18-7482 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ▼ Yes 2 No **Elkton** Marvland Ceci1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 21921 United States 113 West Thomson Drive 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗆 No 1945—
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🌠 Married and Mental Hygiene.

is marked other than "natural", or þ Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🗶 No Specify 3 Widowed 4 Divorced Completed 1966 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) yacht restoration self employed 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ (unknown) Helen Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 is any injury or other tra West Thomson Drive, Elkton, MD 21921 Nancy Ney/wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Foard Funeral Home, P.A. Rising Sun, Maryland 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 21. Signature Tuneral Service Licenses Rising Sun, MD 21911 S. Queen St., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ CONGESTIVE HEART disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) DIABRITES MELLITU and that initiated events Due to (or as a consequence of) resulting in death) Last e attending physician ह न for use as the burial Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death signed by the at d be detached for 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ᅙ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s After this certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 2 | No Accident Investigation completed filled in by the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11/23/10 P. V- naya 00065733 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21921 ELK NN, EAST Smel 141611 PUVA 126

iO FIVA State

Registrar

racke

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician /Medical 4b. City, Town, or Location of Death 4c. County of Death a. Facility Name (If not institution, give street and number) **Examiner** N/A **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 02–22–1933 If Under 1 Year If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) Days **Funeral** Min North Carolina 243-44-8346 **Director** Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 1 ☐ Yes 2 💢 No Director West River MD Anne Arundel 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number USA 1015 Biltmore Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 A No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: þ White 3 X Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Medical (Give kind of work done during most of working life. DO NOT use retired) MD-National Park and Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than Planning Commission 12 secretary or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental F Greene Ρ. Beeker မ Harvey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once. 5139 Cedarlea Drive, West River, MDMark Osborne, son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Pages 1 iment of He 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Lakemont Mem. Gardens 11-26-10 Davidsonville, MD Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. Willia 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final thoraco as domina prured **Physician** disease or condition resulting in death) /Medical (or as a consequence of): Due to Examiner disease arter Coronary Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed nding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day ģ 5 Other (specify) Pregnant at time of death signed by the att 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has 2 🗌 No 21 1 Yes 1 TYes certificate 26. Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical filled in by the funeral director, Be examiner? Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 2 ER/Outpatient 3 🗌 DOA ၉ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation Injury After 1 Natural 1 Yes 2 No after death. Director: Aft 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) 4 - Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only Medical within 24 hountly the total to the total to the total 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number - mas

ARW ID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

31. Date filed (Month, Day, Year) 32. Registra's Signature NOV 2. 9 2010 Server S. Sanks

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** 16:38 PM JOSEPH R. OTTO NOVEMBER 10, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16 AUGUSTINA DRIVE ELKTON CECIL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 □ F Days Months Hours Min 74 Yrs Director 221-20-9226 3/26/1936 NEW JERSEY Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. • marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shor Examirer must be politied at 1 □Yes 2 □ No Director MD CECIL ELKTON 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 16 AUGUSTINA DRIVE 21921 UNITED STATES Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 OFFICE DIRECTOR UNION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked o ပ RAYMOND A. OTTO MARY A. SKINNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum once. DOLORES M. OTTO/WIFE 16 AUGUSTINA DRIVE ELKTON, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State GRACELAWN MEMORIAL
PARK 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/15/2010 NEW CASTLE, DE 21. Signature of Funeral Service Licen 22. Name and Address of Facility SPICER-MULLIKIN FH 1000 N DUPONT PKY NEW CASTLE, DE 19720 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on e used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of attending physician and for use as the burial-tran burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate 1 ☐ Yes 2 2440 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this eral Director: After thi filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 To the and manner stated. 29b. Signature and little of certific 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21 MONSON oria 31. Date filed (Month, Day, 32. Registrar's Signature Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra MEND#23aI+IIpenND,11/24/10,BWW,McCcCertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month NOVEMBER Day Yea 20,2010 Physician/ :45AM SARA LEONOR ORIOLO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours Min Dec. 6.1930 Argentina Months 214-54-3976 79 Director Usual Residence of Decedent 10a. State Mary Land Frederick 10d. Inside City Limits 28a-f shor 10c. City Town or Location Frederick death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Directo 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 2050 William Franklin Drive 21702 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. "natural", or à 1 Never Married 2 Married Maryland 21215-0036 filed within 72 hours after White 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify 3 Widowed 4 □ Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) University of Maryland Baker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any Injury or other traumatic eve (unk) Alfredo Lopez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2050 William F**rank**lin Drive Frederick, Maryland 21702 19a. Informant's Name/Relationship (Type, Print) Steven Oriolo -son Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 11/21/2010 Alexandria, Virginia 4 Donation 5 Other (Specify) Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, 21. Signature of Funeral Service License Û PA Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAILURE RENAL ALUTE Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Metastatic Ovarian Cancer Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and I for use as the burial-tr that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ASPIRATION PNEUMUNIA 2 NO 1 Yes 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Tyes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Opatient 2 ER/Outpatient 3 DOA 2 27. Menner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 3 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0063498 11/20/10 ろ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Lakhuinder Wadhwa, M.D. 400 West 7th Street Frederick, Maryland 21702

State

Registrar

31. Date filed (Month, Day, Year)

NOV 24

Markey

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 28 Pay 201 0 Nov. Physician/ 18:53 P™ PEARCE KALEN MORRIS Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days Hours Min. Country) 1 □ M 2 🛣 MD 59 **Director** 219-56-3709 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b, County 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at Director 1 🗌 Yes 2 🔀 No MD Harford Street 28a-f 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 23a Funeral 21154 U.S.A. 4337 Madonna Road and 2 should be filed within 72 hours after death v Health and Mental Hygiene. tem 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21275-0036 1 Yes 2 No Specify: Specify: White Completed 3 XWidowed 4 Divorced Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Cook Supermarket Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Ellen Holcomb Raymond H. Morris, Sr. Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Woodsview Drive, Red Lion, PA 17356 Craig A. Hoyle/Son Baltimore, 38 20b. Place of Disposition (Name of Mccemeter, cremator, or other place Tion Method Church Cemeter) 20c. Location - City or Town, State 20a. Method of Disposition Page 1 s Dec. 1 Nurial 2 Cremation 3 Removal from State 2010 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, MD 22. Name and Address of Facility J. J. Hartenstein Mortuary, Inc. Second Street New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the gleath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician/ es Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Cause (Disease or linjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) Physician/Medical as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 I Inknown Hospital or Attending Physician: The law requires that the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 🗌 No Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗌 No 1 Inpatient 2 KER/Outpatient 3 DOA မ After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending work? 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours a Funeral D 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier npleted f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F complet only one) 29b. Signature and title of Name and address of person who completed cause of death (Item 23a) (Type, Print) (0

State Registrar 31. Date filed (Month, Day, Year)

32. Registra s Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ $11/22^{Day}2010$ A M Casimir C. Petraitis 7:23 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Prince George's Hospital Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 M 2 □ F Days Hours Vytenai, Lithuania Director 059-44-9898 83 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location aţ Director ral", or items 23a or 28a-f sl Examiner must be notified 1 X Yes 2 No MD Prince George's Cheverly 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 72 hours after death with 20785 USA 2805 Cheverly Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. "natural" 3 Widowed 4 Divorced White Completed Year or Dates Il Hygiene. I other than "natura vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monee. Elementary/Seconday (0-12) Researcher Library of Congress 5+ Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) မ Marcele Vasiliauskaite Zenonas Petraitis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2819 Cheverly Avenue, Cheverly, MD 20785 Elizabeth Bellamy / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Metropolitan Crematory 11/29/10 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death CARDIAC Immediate Cause (Final ARRHYTHMIA FATAL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner DISEASE ORONARY ARTER Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami e Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours after death.

Puneral Director: After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **10**10 1 🔲 Yes **Ø**Inpatient_2 ☐ ER/Outpatient_3 ☐ DOA ျ Date of injury (Month, Day, Year) 27. Manner of De 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Aatural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 7 ☐ Suicici 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the To the I only one) 29b. Signatute and title of certifier ۵

State Registrar 31. Date filed (Month, Day, Yea NOV 2 9 2010

32. Registrar's Signature

cause of death (Hern 23a) (Type Brint) PECANTILE LANC. LARGO. MD 20774

				partment of Health and Nertificate of Death		ene	39051						
1/2	. A 1		Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Dea									
	Physic		C. l Humbauta Daabaa		NOVEMBE	R 25 20n	8:25 AM						
	/Medi Examii		Carlos Humberto Pacheco 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat							
. 4			Prince Georges Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Cheverly #Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince	Georges						
2.0	Funeral Director		1⊠ M 2□ F Vro	Months Days Hours Min.	(Month, Day,		hplace (State or Foreign untry)						
n Sept			220-13-4001 55 Usual Residence of Decedent		10/11/	1955 ET	Salvador						
	ylan		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits						
	Ma 9-f	Director	MD Montgomery Silver	Spring			1 XYes 2 ☐ No						
	th the	lre	MD Montgomery Silver 10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?						
	th wi	ain	1508 Korth Place	20902	E	l Salvad	or						
	dea ms	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sp ff Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, White							
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Heatih and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28e-f show or other treumatic event, the Marucal Examinar must be natified a	þ	1 Never Married 2 Married 1 Yes 2 No ff Yes, Give Year or Dates:		tral Am								
2-0	72 hc	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation ive kind of work done during most of work	1	6b. Kind of Business/	Industry						
2	thin 6.	nple	Elementary/Secondary (0-12) College (1-4or 5+)	a. DO NOT use retired)	arig								
2	ydien Agien Agrith	Con	3rd Lab	orer		Carpente	r						
פ	be filed ntal Hygid of other	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, M	aiden Sumame)							
<u>yla</u>	should I ind Meni marke	2	unknown	Lidia	Del Car	men							
a	2 sho			ailing Address (Street and Number or Run									
2	1 and 2 Health tem 27 i		Irma Rodriguez life partner 150	8 Korth Place S	ilver S	pring MD	20902						
Ore	of H If Iter		20a. Method of Disposition 20b. Place of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	rematory or other place)	Date 2	Oc. Location - City or	Town, State						
Ē	Parit Parit		4 □Donation 5 □ Other (Specify) Chesap	eake 11/	29/10 B	eltsvill	e, MD						
ä	permit. Departr Importe any injugance.		21. Signature of Funeral Service I censee	22. Name and Address of Facility Mi	dAtlant	ic Crema	tion Soc.						
_	20559		Klound Just 7	829 Belle Point									
			23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										
•	Physician		Immediate Cause (Final disease or condition Sebsis										
	/Medical		resulting in death) Due to (or as a consequence of):	1									
1	Examiner	Ç.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):										
	p i	Inel											
	ecute and trans	аш	that initiated events c										
ő	ate be executed thysicien and the burial-transit	dical Examiner	Due to (or as a consequence of):										
8760	the the	l Ca	d										
9 ×	The law requires that the death certificate ite has been signed by the attending physioage 2 should be detached for use as the t	by Physician/Me	IF FEMALE:										
Вох	atteneration	lan		B Ectopic pregnancy		23d. Date of del Month	very Day Year						
o.	the s	yslc	1 Yes 2 No 4 Pregnant at time of death 5	5 Other (specify)			,						
Q.	that ti	P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part f	23e Did tobs	acco use contribute to	the cause of death?						
ďs,	sign sign d be	b b		underlying cause given in raint.		2 □No 3 □ Pr							
Ö	requ	etec			10.163	. 2540 00	——————————————————————————————————————						
3ec		Completed			24a. Was an autopsy	prior to o	topsy findings available completion of cause of						
E		S			perform 1 Yes 2	ed? death? ☐No 1 ☐ Yes	2 🗆 No						
Division of Vital Records,	Physician: The la r this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	04	h (Check only one)							
o	Phys this al dir	ဥ	Tightent 2 ER/Outpati			ice 6 Other (Spec	city)						
5	Jing After funer	on	1 Natural 5 Pending (Month, Day Year) Injury	/ Work?	28d. Describe hov	v injury occurred							
S	death. ctor: A	lcat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	006 1								
<u>></u>	after Direct	Certification;	4 Homicide 4 Homicide 4 See. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town,	eet and Number or Ru State)	rai Houte Number,						
	Hospitel or Attending Ph 24 hours after death. Funerel Director: After th tely filled in by the funeral	Ö	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de										
	Hos 24 h Fur stely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurr	and due to the cat red at the time, dat	ise(s) and manner as e and place, and due	to the cause(s)						
	To the within 2 To the complet	Me	29b. Signature and title of pertifier	29c. License number	29	d. Date signed (Monti	n, Day, Year)						
	10) A MD	00060100	/	1-22-	10						
	Ka.		30. Name and address of person who completed cause of death (Item 23a) (Typ		1 1/	11 - co							
	AT		So, Name and address of person who completed cause of death (nem 25a) (type	San Strains	hop rin	1 4 4 6 2)							
983	Sta	te	21 Date filed (Month Day Year) 22 Popietrade Signature	, no	/	- / · J							
	Registr		NOV 2 9 2010 Server S. Sparrel										
DHI	MH 17 Rev 1/20	001	plane & parket										
			ORIG	INAL									

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11/19/2010 r 10:52 pm Felicita Maria Powers Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 14514 Church Street Upper Marlboro Prince George's . Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 T Hours Min. Director 216-46-4453 94 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Upper Marlboro 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 14514 Church Street 20772 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black. White, etc. þ 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 ☐ Yes 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Completed 3 ₩ Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employeed Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mamie H. Koch George A. Buchheister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Y. Clagett/Son 14714 Main Street, Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State Lee Crematory 11/26/2010 Clinton, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility $^{22.\,\text{Name and Address of Facility}}$ Lee Funeral Home Calvert, 8125 Southern Md Blvd., Owings, MD 20736 Mounts M 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Exami To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Nuneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🗷 No Other: 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? (Month, Day, Year) 1 Natural 5 Pending Accident Investigation 1 Yes 2 No Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of cert

Registrar
DHMH 17 Rev 7/2009

SRW LO

Arnu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

duckente

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November ^{Day} 20 2010 Catherine Peters Рм Patricia 7:41 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Sunrise Assisted Living Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 23 9. Birthplace (State or Foreign Country) New York 6. Sex Funeral 7. Age (In vrs. last birthday) 1 M 2 X F Hours 099-12-3148 Director 89 Oct. Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2K No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10235 Allview Drive 21701 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married þ Specify: White 1 ☐ Yes 2 X No Specify: 3 ₺ Widowed 4 □ Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be permit. Page 1 and 2 should be filed in Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Robert Walsh Frances Gertrude Hennesev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert D. Peters / Son 4 Challedon Court Walkersville, Maryland 21793 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) November 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Mt. Olivet Cemetery 27, 2010 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Signature of Funeral Service Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the discussion or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that the death certificate be executed Cause (Disease of injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the bunal-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year 1 Yes 2 ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 L No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living Hospital 1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation 24 hours after death. Funeral Director: At 2 🗌 No Accident completed filled in by the 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check A Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and tille of certifier 29d. Date signed (Month, Day, Year) 11/24/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Starting Ct Woodbine Md 's Signature State 3 Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle (4ast) 2. Date of Death 3. Time of Death Physician/ NCUS Medical Name (if not institution, give street and number) Examiner 8. Date of Birth (Month, Day, March 2 **Funeral** Age (In yrs. last birthday) If Und If Under 24 Hrs 9. Birthplace (State or Foreign 1 2 M 2 D F Months New York 132-01-8680 90 Director Yrs 1920 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Frederick New Market 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 5514 Talbot Drive 21774 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", Completed 3 🛮 Widowed 4 🗆 Divorced Year or Dates. WWII White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Electronic Engineer N. S. A. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louis Pincus Leah Unkown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Pincus / Son 5514 Talbot Drive, New Market, Maryland 21774 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State Judean Memorial Gardens 4 Donation 5 Other (Specify) <u>Olney, Maryland.</u> . Signature of Juneral Service 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Homes Pike, Prederick, Maryland 21702 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Dementia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Day Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown Completed plnods peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has page 2 s autopsy perforn death? this certificate 1 Yes 2 X No Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p. 25. Was case referred to medical Be 28. Place of Death (Check only one) examiner? 1 Yes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 🛛 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29d. Date signed (Month, Day, Year)

D

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Margaret Elsie Parks November 6:12 P.MM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Months Days Hours Min 07/31/1915 Director 081-38-6383 Canada Usual Residence of Decedent nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🛛 No Maryland |St. Mary's St. Mary's City 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 18150 Shipping Point Road 20686 <u>United States</u> 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married 2 X Married ğ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Bruce MacIntosh Margaret Durin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgar L. Parks/Husband Box 26, St. Mary's City, MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Cre 11/26/2010 Charlotte Hall, MD 21. Signal of of Fred Seprice Line Seprice L 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Jr. M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final railu Onset and Death Physician/ Thrive disease or condition Medical resulting in death) Examiner Demen his Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine and the burial-tran that initiated events resulting in death) Last diseane Physician/Medical Vasculer or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atte Month Day 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed? Yes 2 No After this certificate 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, å 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) No Hospital Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death . Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours at To the Funeral D Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 62213 23 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) onur town Syresh 22650 cedas lune 01 Pat MD

DHMH 17 Rev 7/2009

State Registrar strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Mai					ZUIU	39056	
		Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death							3. Time of Death	
	Physicia Medi		Robert Clinton Perry			November	24, 2010	3:00 p.M		
	Examir	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Ridg	r Location of Death		4c. County of Dea		
	Funeral					If Under 24 Hrs.	8. Date of Birth	St. Mary's 9. Birthplace (State or Foreign		
	Director	ı		49 Yrs.	Months Days	Hours Min.	(Month, Day, Ye 09/02/19	ar) C	Germany	
	ind show at	'n	Usual Residence of Decedent 10a. State 10b. County 1	0c. City, Town or L	ocation				10d. Inside City Limits	
	Maryla 28a-f s	rect	Maryland St. Mary's	Ridg	e				1 ☐ Yes 2 K No	
	h the		10e. Street and Number		10f. Zip Code	20	1 -	. Citizen of What C	ountry?	
	je 1 and 2 should be filed within 72 hours after death with the Maryland to f Heatth and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral Director	48593 Seaside View Road 11. Marital Status 12. Was Decedent Eve	- i- 110	2068			USA		
9	er de or ite	by F	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Eve Armed Forces? 1 □ Yes 2 ☒ No		. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto I	city Yes or No- Rican, etc.)	14. Race - Am Black, Whi		
93	urs af tural", al Exa		3 Widowed 4 Not Divorced If Yes, Give Year or Dates.		1 ☐ Yes 21K No	Specify:		Specify:	White	
75	72 ho n "nai Aedic	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occup e kind of work done o DO NOT use retired)	ation during most of worki	ng 16	b. Kind of Business	Industry	
212	within giene. er tha	To Be Cor	Elementary/Seconday (0-12) College (1-4 or 5+)	iiie.	Bartende	r		Restaur	ant	
Maryland 21215-0036	e filed Ital Hy ed oth		17. Father's Name (First, Middle, Last)				(First, Middle, Maid			
IZ Se	ould build build Mer mark matic		Louis Joseph Perry 19a. Informant's Name/Relationship (Type, Print)			Sieglin				
Ž	d 2 sh alth ar 27 is or trau	1	Elizabeth Hall/Sister		ling Address (Street a					
ore,	of Hear		20a. Method of Disposition 1 Burial 2 🔀 Cremation 3 🗆 Removal from State	20b. Place of Disp				c. Location - City or		
ţį	t. Page tment c tant: If jury or		4 ☐ Donation 5 ☐ Other (Specify)	Brinsfie	1d-Echols	11/3	0/2010 Ch	arlotte	Hall, MD	
The property of the property o										
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	e death. Do not en	ter the mode of dying	g, such as cardiac o	respiratory arrest,		Approximate Interval Between	
æ	Physician/ Medical	1	Immediate Cause (Final disease or condition resulting in death) a. Adomy ocardial fibros. S							
F	Examiner		Due to (or as a co	onsequence of):						
	icate be executed physician and sthe burial-transit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying							
		Examiner	Cause (Disease or linjury that initiated events c	onsequence of):	uence of);					
0	be ex/sician	edical	d							
68760	tificate ng phy as the	Med	IF FEMALE:			-				
9 x	ith ceri		23b. Was decedent pregnant 23c. If yes, outcome of properties in the past 12 months?	Fetal death 3	Ectopic pregnanc	y		23d. Date of de		
Box	he dea y the a ched f	Jysic	1	ne of death 5	Other (specify)			Month	Day Year	
P.0.	that the	by PI	Part II. Other significant conditions contributing to death but r	ot resulting in the	underlying cause give	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?	
- 0 0 0						2 No 3 P	Probably 4 □ No 3 □ Probably 4 □ Probably 2 □ Probably 4			
000	law re has be je 2 sh	Completed					24a. Was an autopsy	prior to	topsy findings available completion of cause of	
E E	in; The lifticate or, pag		25. Was case referred to medical	-	OS Dia	ice of Death (Check	performed	? death? No 1 ☐ Yes	2 2 N o	
Vita	nysicia iis cert direct	To Be	examiner? 1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient	2 ER/Outpatie	Otho		ne 5 Residence	6 Other (Spec	ify)	
) of	ling Pt		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Ye	28b. Time o ear) injury	work?	at 2	8d. Describe how in			
Sior	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 to make the completed filled in by the funeral director, page 2 to make the completed filled in by the funeral director.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	At home farm st		Yes 2 □ No	06.1 1: (04		18 14 1	
Divi			4 Homicide determined 286. Place or injury - building, etc. (S	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	he Hospi in 24 hou ne Funer pleted fill	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my Check only one) 3 Certifying Nurse Practioner: To the best of my Certifying Physician: To the best of my Certifying Physici	ination and/or inves	STIMATION IN MY ONINIOR	a death accurred at t	ha time date and alc	and due to the	source/a) and manney stated	
	To t To t com		29b. Signature and title of certifier		29c, License			Date signed (Month		
		-	30. Name and address of person who completed cause of death	/ltom 99=) //	DG Delinal	2042	D	11/29/10	1	
3)4	mo		30. Name and address of person who completed cause of death 28103 Three No trub	(Rem 23a) (Type, I	ste 101	Mechan	Bauer icsville.	MD Ana	59	
	Stat Registra	~	31. Date filed (Month, Day, Year) NOV 3 0 2010 32. Registrar's	Signature A. A	barker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Green 130 A.M. Medical Nov. 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Queen sonville 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Mary and **Funeral** 1 🗆 M 2 🖼 F 213-24-159 9 Director Usual Residence of Decedent 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director item 27 is marked other than "natural", or items 23a or 28a-f s other traumatic event, the Medical Examiner must be notified Grasonville Queen Hnnes 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21638 Main 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 should be filed within 72 hours after If Yes Give 1 ☐ Yes 2 KNo Specify. Black 3 XWidowed 4 ☐ Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Health and Mental Hyglene. life. DO NOT use retired) Elementary/Seconday (0-12) County Bd of Ed College (1-4 or 5+) leacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) arilyn Washington Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 27/2010 Signature of Funeral Service Licenses uneral Home, P.A. owashington MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) en Medical Due to (or as a consequence of) Examiner 10 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day the g Unknown b detach signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Tunknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 sl autopsy this certificate perform Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ► No funeral director, Be 26. Place of Death (Check only one) Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending work?
1 Yes thin 24 hours after death.

the Funeral Director; A simpleted filled in by the fu 2 🗆 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

To the I

complete only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 23 12010

Registrar

State

JEFFRE

Correntle

21617

NO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2540

2. Registrar's Sign

UKERY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State #1 & 19A, Per f.h & phys. Certificate of Death 12/1/10, E.T., WCHD Amended item 🕇 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 21 Physician/ Mary Isabelle Riordan Month Mary Isabell Riordan Noevmber 2010 $12.05P^{M}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing Home Worcester 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country)
 MD If Under 24 Hrs. **Funeral** If Under 1 Year 8. Date of Birth Days Months Hours Min. 1/271916 **Director** 213-01-7330 94 Yrs. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No MD Worcester Libertytown Rd. 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 7821 Libertytown 21811 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2x No If Yes, Give Year or Dates 1 Yes 2X No Specify: Specify: white Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Photo lab Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Ackermann Malina Dickie Rioridan, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Eileen M. Pitcher Eileen M. Pitchard 7821 Libertytown Rd. Berlin, MD 21811 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Millsboro, DE State Crematory 11/22/2010 Funeral Service Lieensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 una 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final Onset and Death MONIC Physician/ obstru disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 XNo To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Tes 2 X No 1 Inpatient 2 I ER/Outpatient 3 I 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending I Director: A 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 8 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

thin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 XCertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 7 29b. Signatur and title of certifier 29d. Date signed (Month. Day. Year) R 135131 November 22, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Healthway Dr, Berlin,MD Pennie Savage, CRNP 21811 31. Date filed (Month, Day, Year) State NOV 23 2010 Registrar **ORIGINAL**

Mary

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ The November 19 2010 Medical 05/4 AM 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Grove Ad ventist Rockville Montgomer Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 1 🛛 M 2 🗆 F 254-15-3721 4/19/10 0 05/4 Director Hours 09/21/1953 Yrs 57 Washington. Usual Residence of Decedent show 10b. County ŧ 10a. State 10c. City. Town or Location Director 10d. Inside City Limits Examiner must be notified 28a-f Maruland Montgomeru Germantown 1 Yes 2 No 10e, Street and Number "natural", or items 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 12709 Found Stone Road. 20876 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? þ 1 🕱 Never Married 2 🗌 Married Black White etc. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 Divorced 4 Divorced Specify Caucasian the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic many Elementary/Seconday (0-12) College (1-4 or 5+) None None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be 1 Herman A. Roth Betty M. Capes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claire Theresa Roth - Sister 11812 Trailridge Drive, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 11/26/2010 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute Funeral & Cremation 1040 Rockville Pike. Rockville. MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) oex coon i on or as a consequence of): Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): signed by the attending physician and id be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury Due to (or as a consequence of): that initiated events resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No 1 Yes 2 9 Unknown Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Sleep Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has It funeral director, page 2 s performed? Yes 2 X No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2xaminer? 1X Yes မ 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 \square Pending work? in 24 hours after death.

Refuneral Director: A pleted filled in by the fu Swinging on repe 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 No Summer 1970 Investigation Unk Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Brunswick Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed f (Check 3 only one 29b. Signature and title of certified ٥ 29c. License number 10 1000Mpsv 185010 Drilles 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grungatour mo 20874 29 7 Decteristrice anti 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

NOV

24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month VOV binso 5:00 AM 2010 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Nursing+ Rehab Denton voline Center Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 ☑ M 2 ☐ F 8. Date of Birth (Month, Day, Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 836 Min. North Carelina **Director** Usual Residence of Decedent 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c, City, Town or Location must be notified at 10d. Inside City Limits Funeral Director or 28a-f 1 ¥Yes 2 □ No 14/OCK 10e, Street and Number 10g. Citizen of What Country? items 23a reek 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Baltimore, Maryland 21215-0036 Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) (n Mechani of Health and Mental Hygie item 27 is marked other other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) reek Rd. Mae obinson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date of Important: If it any injury or o 1 M Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 30/10 Washington Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Henry Funeral Home MD, 2/6/3 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Yes 2 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Hiknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate Yes 1 Yes 2 No completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1, Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Year) 32. Registrar's Signature State Registrar

Registrar
DHMH 17 Rev 1/2001

6

State

Shahid

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mahmood

580C

32. Registrar's Signature

Washington 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Manufacture of Shoes Hoffman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 East Antietam St., Hagerstown, MD 21740 20c. Location - City or Town, State Boonsboro, Maryland 22 Name and Address of Facility
Andrew K. Coffman Funeral Home, Inc. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. 23d Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Yes 2 No Other Nursing Home 5 Residence 6 Other: After this inneral 28a Date of Injury (Month, Day, Year) Certification: Sep 14, 2010 Subject fell 1 Natural 2030 hrs Pending 1 Yes 2 V No within 24 hours after death.

To the Funeral Director: the i 2 🗸 Accident Investigation in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) 17529 Lincolnshire Road, Hagerstown, MD filled Home determined (Specify) Single Family Home 4 Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 21 and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and 29c, License number O.C.M.E. November 16, 2010 MRIPPLE address of person who completed cause of death (Item 23a 3 Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

39062

3. Time of Death

0050 hrs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 December ATITA JEANNETTE Medical SIEGERI 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Ye December 18 1 🗆 M 2 💢 F Months Hours Maryland Director 215-26-8674 80 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Frederick Frederick Maryland 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 5625 Crabapple Drive 21703 United States hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Force 1 Never Married 2 Married þ ☐ Yes 2 🎇 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3X Widowed 4 □ Divorced I Hygiene. other than "natura vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) within 72 College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home nt of Health and Mental Hygie t: If item 27 is marked other or other traumatic event, the Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William B. Willard Lillian R. Engelbrecht je 1 and 2 should b t of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Siegert / Son 5145 Orchard Green, Columbia, Maryland 21045 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 4 X Burial 2 Cremation 3 Removal from State Department or Important: If any injury or 2010 4 Donation 5 Other (Specify) Mount Olivet Cemetery Frederick, Maryland 21. Signature of Funeral Service Licenses Keeriew Adni Bastord PA Funeral Home, M M01473 Church Street, Frederick, Maryland 21701 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disea shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) metastatic Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 COPD 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available certificate has autopsy prior to completion of cause of death? performed?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 🗆 Yes 2 No Other: ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Natural work? 5 Pending Accident Suicide Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town. State the Hospital Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Chec 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H Thomas 65 c <u> 5404</u> te filed (Month, Day, Year)
DEC 1 0 2010 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November Edwin Statkus 9:41 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctor's Community Hospital Lanham Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 08-10-1926 Months Days Hours Min 578-30-2574 MD **Director** Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland notified at Director 1 X Yes 2 □ No MD Prince George's District Heights 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 7420 Marlboro Pike 20747 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Divorced "natural" Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the Manay injury or other traumatic event the Manay life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Postal Service 10th Mail Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ (Unava.) (Unava. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6420 Allentown Rd., Camp Springs, MD 20748 Claudia Johns/Guad.of Pers 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-18-2010 Crem. Riverdale, verdale 21. Signature uneral Service Licersee 22. Name and Address of Facility 20746 Cedar Hill FH,4111 PA Ave.,Suitland, MD23a. Part of Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physicianz espiratny disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sequence of) ending physician and use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Day 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate has page 2 1 Yes 2 No Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending injury s after death.

I Director: Aft

ed in by the fur 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined building, etc. (Specify) 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 To the I 29b. Signature and title of certifie

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

who completed cause of death (Item 23a) (Type, Print) 8118

Good

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Vovember Year PM Physician/ 2010 Moore Simpkins Verdell Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Doctors Hospital Lanham If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral (Month, Day, August 1 🗆 M 2 🕱 F Months Days Hours Florida 263-74-5066 68 .1942 Director Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Director be notified 28a-f 1 X Yes 2 No Prince Georges Upper Marlboro Marvland 10f. Zip Code 5 10e. Street and Numbe 10g. Citizen of What Country? Funeral 23a with United States 20774 11907 Wimbleton Street **Examiner must** or items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married þ hours after 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates er than "natur , the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) U. S. Department of College (1-4 or 5+) Elementary/Seconday (0-12) Hygiene. Transportation Transportation Specialist 1 year and Mental Hygier is marked other t Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) ည **Brooks** pe Florence Robert Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 11907 Wimbleton Street; Upper Marlboro, Maryland Joseph Ernest Simpkins (Husband) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov.30,2010 1 X Burial 2 Cremation 3 Removal from State injury or Maryland Cheltenham Veterans Cemetery; Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility R. N. Horton Company Morticians, Signature of Funeral Service Lice Inc.;600 Kennedy Street, N.W.; WAshington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of resulting in death) Last physician ar s the burial-t Physician/Medical P.O. Box 68760 attending p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 9 Unknown 9 Unknown signed by tl d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 2 🗌 No certificate Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 🗌 Yes 2 1 No 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, ည this : After this funeral of 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural injury 5 Pending 1 Yes 2 No within 24 hours after death to the Funeral Director: A completed filled in by the f Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIE 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9:05 November Ruth Snider Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Calvert Prince Frederick Calvert Memorial Hospital Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. 10-07-1920 California Director 90 444-16-4918 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No MD Calvert Chesapeake Beach 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 3750 Bristol Drive 20732 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 2 X No 1 X Yes 2 ☐ No Specify: If Yes, Give "natural", Specify: 3 X Widowed 4 Divorced Mexican white Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Roland Angie Gomez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3750 Bristol Drive, Chesapeake Beach, MD Patricia Snider, daughter 20732 20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Metropolitan Crematory 12-3-2010 Alexandria, VA Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. Williams 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-trans resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 Yes 2 No 9 Unknown Month Pregnant at time of death ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Tes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsv perform certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completed filled in by the funeral director; to 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{ Residence } 6 \subseteq \text{ Other (Specify, 1 🔲 Yes 2. X No 1 Inpatient 2 KER/Outpatient 3 I DOA ျှ 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 4 Homicide (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) determined

Division of Vital

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

LRW

State Registrar

Medical

29a. Certifier only one) 29b. Signature and fittle of

HZIS 31. Date filed (Month, Day Moderon

Registra s Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D025203

29d. Date signed (Month, Day, Year)

EMERGENCY 2T MEMOR

MEMORIAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 24, 2010 Year Hannah S. Sorrell 11:30 p м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Solomons Nursing Center Solomons Calvert 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🕱 F Months Days Hours (Month, Day, You March 21 Director 220-36-0080 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 28a-f 1 🗆 Yes 2 📉 No Calvert Lusby 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe Funeral 23a 615 Sollers Wharf Road USA 20657 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner r 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: If Yes, Give Specify 3 X Widowed 4 □ Divorced Completed Year or Dates Black Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ovster Shucker Seafood Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 6 William Dawkins Sr. Mary Ann Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Dawkins - daughter 7921 Gilbert Street, Philadelphia, PA 19150 other 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State St. John UM Church Cemetery December 1, 2010 4 ☐ Donation 5 ☐ Other (Specify) Lusby, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A. Blader 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Dela 9 Sequentially fist conditions, Examiner Due to (or as a consequence of) il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Enveral Director: After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transit eled filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE . If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CANCER COLON 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed Yes 2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 1 No Other: 1 🗆 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 🗌 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D3696 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCARIA LUSBY MD 2065 MATHEW MD PO BUX 1789 31. Date filed (Month, Day, Year) 32. Registra s Signature State 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 20, 2010 Year Physician/ 9:29 a M Rachel Elizabeth Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Calvert 1630 Coster Road Lusby 8. Date of Birth (Month, Day, April 13, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Days 1 □ M 2 💢 F Months Hours MD Director 213-56-6083 Usual Residence of Decedent 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.
Health and Mental Hygiene.
tem 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1630 Coster Road 20657 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No If Yes, Give 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Black Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Farmer Farming Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Rachel Chase Thomas Leroy Mackall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1630 Coster Road, Lusby, MD 20657 Patsy Freeland - daughter Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Young's Church Cemetery November 27, 2010 | Huntingtown, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Sewell Funeral Home, P.A. Dade 1451 Dares Beach Rd., Prince Frederick, MD 20678 a'. 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final zeinoma Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of if any leading to in medicause. Enter Underlying requires that the death certificate be executed Cause (Disease or linjury for use as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) cate has been signed by the a page 2 should be detached in 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown OBSTRUCTIVE 1 Tes 24b. Were autopsy findings available Essential 24a. Was an prior to completion of cause of death? To the Hospital or Attending Physician: The law within 24 hours at er death.

To the Funeral Director: After this certificate has k completed filled in by the funeral director, page 2 s autopsy performed Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital examiner? 2 X No 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Watural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c, License number -2010 00019427 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , PRINCE FREDERICK M.D HOSP. RD MUNSHI. 130 (CM ANWAR 31. Date filed (Month, Day, 32. Registra s Signature State NOV 29 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Year Grant Smith wood 2010 Vovember 2a 0600 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Salisbury Rehabilitation + Nursing Ctr. Wicomico lisburg 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)
Maryland **Funeral** 1 ∰ M 2 □ F Min Hours Director 216-38-7519 Feb. 194 Usual Residence of Decedent show 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified 28a-f Maryland Somerset Westover 1 Yes 2 No 10e. Street and Number ò 10f, Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral U.S.A mennonite Church 8401 21871 12 Was Decedent Ever in LLS 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after valepartment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: Black 3 ☐ Widowed 4 MDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Custodian 12th grade Somerset County Bd. of Ed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Savage William Elsie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Smith -Sister Christine Rd Mennonite Church Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State -27-10 4 Donation 5 Other (Specify) John Wasley U.Mc Cemetery Ameral Service Licensee 22. Name and Address of Pacility Anthony 4. 30639 Princes Anne med 21853 Hampden 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause one ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition · pour Medical resulting in death) Due to Examiner ea, Sequentially list conditions, Examine if any, leading to immediate cause. Enter onderlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): igned by the attending physician and be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records. P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 Ato 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 2 🗌 No 1 Yes Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 | Yes 2 | 1 | Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? Accident 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a 29a. Certifier 1 Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 lilliam State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ LINDA MARIE SNYDER NOVEMBEF 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Nov 27 Day, 1 M 2 KX 56 Mary Tand 216-60-2657 Director Usual Residence of Deceden show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits filed within 72 hours after death with the Maryland Director Frederick Frederick Maryland 1 🗌 Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21703 Funeral 6226 Derby Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2XX Married 1 ☐ Yes 2XXNo If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. White Specify. 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) ie 1 and 2 should be filed within 7 tof Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Ms Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Shirley Nolan Thomas Smead 19a. Informant's Name/Relationship (Type, Print)
Thomas Snyder – husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21703 6226 Derby Drive, Frederick, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ᇴ permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State 11-29-2010 Stauffer Crematory Frederick, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home re of Funeral Service Licenses 1621 Opossumtown PIke, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Myocardial Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury as the burial-tran and that initiated events resulting in death) Last attending physician ension Physician/Medical Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown for Dav Year detached the g Unknown ģ er significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2000 September 1 September 1 September 1 September 1 September 2 S 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Completed by 4 Unknown Records, 1 Yes 2 No 3 Probably Obstructive Pulm many Disease 24a. Was an autopsy 24b. Were autopsy findings available prior to comp death? letion of cause of perform No Yes 1 Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t **Division of Vital** 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 IDOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASUNCION

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 10:48 PM Decedent's Name (First, Middle, Last) 2. Date of Death Saul Sitzer **Physician** November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner och Raven Community Living Baltimore Baltimore Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 070-18-9386 1**X** M 2□ F Director Apr. 20, 1924 New York 86 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at MD Baltimore Baltimore 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9444 Seven Courts Dr. 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Ye ar or Dates: 1944-72 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify þ 3 Widowed 4 Divorced "natural" s 1 and 2 should be filed within 72 ho of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Air Force of the Elementary/Secondary (0-12) College (1-4or 5+) United States Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nathan Sitzer Rose Dunn ပ 19bg Mailing Address (Street and Number of Rural Boute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau Evelyn Sitzer/Wife MD21236 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3X Removal from State 12/5/2010 Wilmington, DE Jewish Community 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schoenberg Memorial Chapel 21. Signaturé of Funeral Service Licep 788 519 Philadelphia Pike, Wilm., DE 19809 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ascular **Physician** disease or condition resulting in death) /Medical Que to (or as a consequence of): vebrovascular Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-trans and C. Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy p in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an certificate 2 MNo 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Man or of Death completely filled in by the funeral Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, I hours after death uneral Director: Hospital thin 24 hours a

12+1VA State

within: To the

520 V92 31. Date filed (Month, Day, Year) NOV 2 9 2010

30 Name and address of person

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical

ompleted cause of death (Item 23a) (Type, Print) Loch Raven Bathnove 32. Registrar's Signature

Nich I M.D.

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 24a per hospital G911 1/28/11 dk
State of Maryland / Department of Health and Mental Hygiene | | { 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 11:48 AM August Stevenson 21 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Havre De Grace Harford Memorial Hospital Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days 1**∑**M 2□ F Months Hours Yrs. Delaware Director 83 04 - 15 - 1927222-12-4551 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location th and Mental Hygiene. It is marked other then "netural", or Items 23a or 28a-f ehov traumatic event, the Madical Exocities traust be motified at 28a-f ehow 1 XYes 2 No Director Cecil Port Deposit, Md. 10e. Street and Number All Care Assist. Living 10g. Citizen of What Country? 1505 Belvadere Rd., Port Deposit, Md. 21904 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Specify:White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Self-employed Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth eny lollury or other traumatic event page. Be August M. Stevenson Alice M. Drummond 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O.Box 107, 807 Elk Mills Rd., Elk Mills, Md 21920 Harry Lenderman 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Silverbrook Crematory 11-26-10 Wilmington, DE 21. Signature of Funeral Service Licensee MD_CC9283 22. Name and Address of Facility 2506 Concord Pike Chandler Funeral Home Wilmington, DE 19803 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Infarction **Physician** Myocardia /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, and cause in the underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons yuence of) The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 9 Unknown 9 Unknown After this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed tension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 3₽ No Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes & No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending after death.

I Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in within 24 hours at To the Funeral D completely filled in Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier -Jan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SON MD 501 SUNION AVE HAVE de GRACE SAMIS Day, Year) OhN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 29 2010

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Starr Thomas 2:55P M Ross November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Kent 5859 Crosby Road Rock Hall 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours (Month, Day, Year) Months Days Min Country) Director 214-32-6146 75 MD Usual Residence of Decedent 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 ី No MD Rock Hall Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 5859 Crosby Road 21661 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc ģ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 1 No Specify: should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", Completed 3 Widowed 4 Divorced Year or Dates.1954-1962 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Supervisor Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic v Walter F. Starr Reulah Burris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5859 Crosby Road Rock Hall, Maryland 21661 Caroline Starr - Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 11-22-2010 Chester, Maryland 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral 130 Speer Road Chestertown, Maryland 21. Signature of Funeral Service Licenses Home, 21620 23a. Par 1. Enter the disease, or complication that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events Examin that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown cate has been signated to be a specification and care and Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform this certificate 1 🗌 Yes 2 📉 To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 \square Pending Division 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 🗽 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Numer Fractionar Tythe begins my knowledge death accurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

State

(Check 29b. Signatur

30. Name and address of person with completed cause of death (Item 23a) (Type, Print) Print & SPORT & CORST PARTAIN. NW.

00060301

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** FRANCIS RONALD SYMES 2010 10:24 18, November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Millington Kent 29590 Morgnec Road If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 ☑ M 2 □ F Director 011-28-5047 73 1/22/1937 Boston, MA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 🍇 💃 No Director Kent Millington MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 29590 Morgnec Road USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No
If Yes, Give Year or Dates: 1954 — 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: White Specify: ğ 3 Widowed 4 Divorced 1957 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Car Salesman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be marked Frances P. Sullivan James R. Symes ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S Health a 29590 Morgnec Road, Millington, MD 21651 Mary Symes/Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ★Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/24/10 Chesapeake City, MD Rose of Lima 22. Name and Address of Facility Signature of Funeral Service Licensee DANIELS & HUTCHISON FUNERAL HOME LLC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Middletown, DE Approximate of Interval Baween 9 Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Coronary Artery Disease /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed Mixed Hyperlipidemia Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2X No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🙀 Residence 6 ☐ Other (Specify) YYes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 ☐ Accident 5 Pending investigation s after death.

I Director: At 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Box 68760, P.0. Records, **Division of Vital** the Hospital or Attending Physician: within 2 To the

> Registrar DHMH 17 Rev 1/2001

11 +

State

(Check only one)

29b. Signature and title

Anthony Alfieri,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

32. Registrar's Signature

29c. License number

2002961

MD, 39 Omega Drive, Suite G, Newark, DE 19713

29d. Date signed (Month, Day, Year)

10-09180	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. U U	00
Kurtis Sherman Stepney, Jr.	State of Maryland / Department of Health and Mental Hygiene	

		1 For State Registrar	Certifica	ate of	Death		Re	g. No.		
Physicia	ın/	Decedent's Name (First, Middle,Last)					Date of Deat Month	Day Yes	эг	3. Time of Death 0132 hrs
ledical Examii	ner	Kurtis Sherman Stepne	y, Jr.	14	o. City, Town, or	r Location o	November	30, 2010 4c. County	of Death	
		Facility Name (if not institution, give street and number) St. Mary's Hospital		40	Leonardtov		Deall	St. Mary		
Funeral			n yrs. last birtl	hday)	If Under 1 Yea	ar If Unde	r 24Hrs. 8. Date of Birt	h(MM/DO/YYYY	g. Birt	hplace (State or
Director		N/A 1XM 2F		Yrs.	Months Day		Min. 06/18/	2010	Foreigi Cou	n ^{untry)} Maryland
ıny	ŀ	Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town	or Locatio	n					10d. Inside City Limits
d how a		Maryland St. Mary's	Grea	t Mi	11e					1 Yes 2 X No
Aaryland 28a-f show any 1.81 once,	Director	10e. Street and Number	Orca		10f. Zip Code		10	g. Citizen of WI	nat Cour	itry?
th the Maryland 23a or 28a-f sho notified at once.		45955 Foxchase Drive			206	34		U	S A	
n with	era	11. Marital Status 12. Was Decedent Ev Armed Forces?	er in U.S.				in? (Specify Yes or No- Puerto Rican, etc.)		e - Americ e, etc.	can Indian, Black,
r death or ite	Funeral	1 Yes 2 X	No		_		,	Specific		Black
rs afte	2	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade complete.	eted) 16a. I		Yes 2 X No		kind of work done	Specify: 16b. Kind of Bu		
2 hour	eted	Elementary/Secondary (0-12) College (1-4 or 5+)			st of working life					
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	omple	N/A			N/A			N/A		
5-00 iled wit Hygien I other	O	17. Father's Name (First, Middle, Last)	0				s Name (First, Middle, N			
D 21215-00; should be filed with and Mental Hygiene. T is marked other thatic event, the Med	Be	Kurtis Sherman Stepney, 19a. Informant's Name/Relationship (Type, Print)		Mailing	Address (Stre		eva A. ber or Rural Route Num	Barne ther City or Tow		Zin Code)
MD 2 td 2 shoul lith and M m 27 is m sumatic	2	Kieva A. Barnes/Mother					rive, Great			
		20a. Method of Disposition	20b. Place of	f Dispositi	on (Name of ce		Date	20c. Location		
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 X Burial 2 Cremation 3 Removal from State		ory or othe	Peace		12/04/2010	Helen.	Ma	rvland
Baltir permit. P Departme Importa injury or	ł	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Queen	22. Na	me and Addres	s of Facility	Brinsfield	Funeral	L Ho	me, P.A.
iii iii De		Shawn Aylesworth M01521	n	22	955 Ho <u>1</u>	lywoo	d Rd., Leon	nardtown	1, M	
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.			mode of dying	, such as ca	ardiac or respiratory arre	est, shock, or he	art	Approximate Interval Between Onset and Death
Examiner	п.	Immediate Cause (Final disease or condition resulting in death) a. Cardiac A Due to (or as a consequence)		mia						Death
		Cardiomeg								
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	ience of):		· · · · · · · · · · · · · · · · · · ·					
	ami	(Disease or injury that initiated events resulting in death) Last	ence of):					· · · · · · · · · · · · · · · · · · ·		
cuted ind transit	ă	d.								
760, icate be executed physician and the burial - transit	Medical		,b,pt.1	1,27	per me	g912	2-25-11 vt			
760, ficate be g physic s the buri		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome 1 Live birth	of pregnancy	Feta	il death 3	Ectopic	pregnancy	23d. Date of Month		yay Year
Box 687 he death certific the attending p	Physician/	past 12 months?	ne of death 5		er (Specify)					
Bo te deat the at	hys	1 Yes 2 No 9 Unknown g Unknown		in the con-	1-11-1-1-1	nivenia De	1 220 Did to	hacco use contr	ibute to	the cause of death?
ires that the signed by a be detached	P P	Part II. Other significant conditions contributing to death be Prematurity, Chronic Lun		-	deriying cause	given in Pa				ably 4 Unknown
ords, F w requires s been sig should be		Tremeteries, onreare near	8 2230				24a. Was a	n 24b. \	Were au	topsy findings available
COFC law re has be	Completed						autop:	med?	death?	ompletion of cause of
Vital Reco ysician: The law his certificate has director, page 2 s		OF Warrange of a warding.			26 Plac	o of Death	(Check only one)	2 No 1	✓ Ye	s 2 No
ital sician is certi	Be	25. Was case referred to medical examiner? Hospital: Inpatient	2 V ER/0	utpatient		Other ₄		Residence 6	Other	:
of Vir ling Physic After this funeral dir	. To	27. Manner of Death 28a. Date of Injury	28b.	Time of Inj		ury at Work	? 28d. Describe h	now injury occurr	red	
OOD cendin	tior	Natural 5 Pending	,		1	Yes 2	No			
Division of Vital Records, pital or Attending Physician: The law requirement after death. The law certificate has been similar by the funeral director; After this certificate has been similed in by the funeral director, page 2 should be after the funeral director.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	y - At home, fa	arm, street	, factory, office	building, et	c. 28f. Location (S or Town, S		er or Ru	ral Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examiner	nowledge, dea	ath occurre	ed at the time, o	date and pla	ace, and due to the caus curred at the time, date	e(s) and manner and place, and c	r as state	ed. e cause(s)
To 1 To 1 com	Medical	and manner stated. 29b. Signature and title of certifier				se number		29d. Date sign		
		0-14			O.C	.M.E.		December	1, 201	0
		30. Name and address of person who completed cause of dea	th (Item 23a)							
		Donna M. Vincenti, MD Assistant Medical		111	Penn Stree	t, Baltimo	ore, MD 21201			
St Regist	tate trar	31. Date filed (Month, Day, Year) OFC 0 7 2010 32. Registrar's	Signature	Mar	Kel					
DHMH 17 Rev 1/2		OCME	OR	IGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra/MEND#25, 26per/MD12/1/10, EMW, McCo. Certificate of Death 2. Date of Death 3. Time of Death Physician/ 2010 Margot Strupp November 4:25 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6405 Marjory Lane Montgomery Bethesda Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 M 2 XF Months **Director** 040-24-4360 Yrs. 80 February 5, 1930 Germany Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Me ical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6405 Marjory Lane U. S. A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. à 1 Never Married 2 X Married 1 ☐ Yes 2 🗓 No If Yes, Give Page 1 and 2 should be filed within 72 hours afti ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", 1 ☐ Yes 2 X No Specify: Completed 3 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Oscar Neufeld Freund 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Strupp - Husband Werner 6405 Marjory Lane Bethesda 20817 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 and Department of Hall Important: If Ite any Injury or ot Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🔀 Removal from State cemetery, crematory or other place, King David Memorial Garden 11/14/2010 4 Donation 5 Other (Specify) Falls Church, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility National Funeral Home CC 0517 7482 Lee Highway Falls Church Virginia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 5 years Immediate Cause (Final Physician/ disease or condition resulting in death) Hemangiopericytoma Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine s the burial-transit Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery 1 Live Birth 2 Live Geath
4 Pregnant at time of death in the past 12 months?

1 Yes 2 No Day Year cate has been signed by the a page 2 should be detached to 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 \square Yes 2 \boxtimes No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No this certificate 2 No 1 Yes Hospital or Attending Physician: كا hours after death. Funeral Director: After this مصنائات completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 X No Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending s after death. Accident Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certific 29c. License number

Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5530 Wisconsin Avenue

32 Registrar's Signature

03665 J

Bruce Kressel

31. Date filed (Month, Day, Year)

11 3

Md 2023600

Chevy Chase

Suite 1125

20815

Maryland

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryland /				d Mental Hyo	giene 🦙	010	00077
	_		Registrar	Cer	tificate of D	Peath		Reg. No.	UIU	33011
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Dav	Year	3. Time of Death
	Medic		Cora E. Shaller 4a. Facility Name (if not institution, give street and number)		4. 07. 7.	Leasting of De	Novembe			3:05 p ^M
	Examin	er	7620 Old Georgetown Road, Apt. 73	12	4b. City, Town, or	hesda	auı	4c. Cou	nty of Death	0.000.000
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bi		If Under 1 Year	If Under 24 H		1	9, Birth	gomery place (State or Foreign
	Director		087-03-5828 1 □ M 2 □ xF 93	Yrs.	Months Days	Hours Mi	n. 05/23/1	917	New	York
	nd now	Ē	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tov	n or Lo	cation		- 2		Τ.	10d. Inside City Limits
	anylan a-fsl	Director								1 Yes 2 □ No
	or 28	ğ	Maryland Montgomery Bethes 10e. Street and Number	aa	10f. Zip Code			10a Citizen	of What Cour	
	with t	Funeral	7620 Old Georgetown Road, Apt. 732	,	20814	-6158		109. 012011	USA	
	Jeath items items	Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Specify Yes or No-		Race - Americ	
36	after (I", or camir	l by	1 Never Married 2 Married 1 Yes 2 X No		☐ Yes 2 🔀 No		sto filoan, etc.)	Spec	Black, White,	_{etc.} h ite
8	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	3x Widowed 4 □ Divorced Year or Dates. 15. Decedent's Education 16.		ent's Usual Occupa					
21215-0036	an "n Medi	шb	(Specify only highest grade completed)	(Give F	rind of work done di O NOT use retired)	uning most of w	orking	16b. Kind of	f Business In F.1 em	entary
7	withii giene er th		Elementary/Seconday (0-12) College (1-4 or 5+) 5+		Teacher					ation
nd	tal Hy tal Hy td oth event	To Be	17. Father's Name (First, Middle, Last)			18. Mother's N	ame (First, Middle, I	/laiden Suma	ıme)	
Z	should be filed to and Mental Hyg 7 is marked oth iraumatic event,	-	Charles Eckstein				Milrad			
Maryland		38	19a. Informant's Name/Relationship (Type, Print)	b. Mailin	g Address (Street al 01d Geor	nd Number or F getown	Rural Route Number, Road Apt 20814–615	City or Town	, State, Zip (Code)
	and Heal tem 2		20a. Method of Disposition 20b. Place	of Dispos	sition (Name of	1	20814-615 Date		n - City or To	nun Stata
JOE	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other ance,		1 🔀 Burial 2 □ Cremation 3 □ Removal from State	ery, crem gan	atory or other place Memorial lens)			•	
altimore,	permit. F Departm Importal any injul		21. Signitu of Lucia Schice Licensee				21/2010	C	Iney.	Maryland
9) g g g g g	- 2	M01255	10	WARD SAGI	EL FUNE ille Pi	RAL DIREC ke, Rockv	TION, ille.	INC. Marvla	and 20852
		25	23a. Par 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.							Approximate Interval Between
	Physician/	i ,	Immediate Cause (Final disease or condition Failure To Thr	ive						Onset and Death
-4	Medical Examiner		resulting in death) Due to (or as a consequence							
	墨	Jer	Sequentially list conditions, if any leading to immediate b. Decreased Ambu		on					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury							
	exect an an rial-tr	EX	that initiated events c. Due to (or as a consequence	of):				-		
3	tte be hysici he bu	edical	d							
289	ertifica ling p		IF FEMALE:							
XOX	ath ce attenc for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Live Birth 2 □ Fetal deat 4 □ Pregnant at time of death		Ectopic pregnancy Other (specify)			1	Date of delive Month	ery Day Year
о В	the de y the ached	hysi	1 Yes 2X No 4 Pregnant at time of death 9 Unknown		Cirior (opcony)					
٦. ڪ	that i	by P	Part II. Other significant conditions contributing to death but not resulting					acco use co	ntribute to th	e cause of death?
Vital Records,	quires en sig ould b	ted	Hypertension, Congestive Heart Fa	ilur	e, Celia	c Disea	se l 1□ Y	es 2 K No	3 Prob	oably 4 🗆 Unknown
S	law re ras be	Completed					24a. Was ar		o. Were autop	osy findings available mpletion of cause of
2	cate page						perform 1 Yes	ned?	death?	2 🗆 No
<u> </u>	ician certifi rector	Be	25. Was case referred to medical examiner?		Other	ce of Death (Ch	eck only one)			
01 <	Phys r this eral di	은	1	utpatient Time of	3 DOA 28c. Injury	4 ☐ Nursing	Home 5 X Reside		(-,,)
מכ	nding ath. :: Afte e fune	icat		njury	work?	es 2 No	20d. Describe 110	w injury occu	irred	
DIVISION	er degreector	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, stre	et, factory, office		28f. Location (Str		ber or Rural	Route Number,
5	ital or urs aft ral Dir lled in						City or Town			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/o	or investi	gation, in my opinion	death occurred	at the time date and	Inlace and c	tue to the call	ica(e) and mannar stated
	o the		29b. Signature and title of certifier	ledge, de	29c. License r	lkine, date and p	lace, and due to the	cauca(c) and	ned (Month, L	ited.
	A		PIOLICE IN	V		2105				2, 2010
	.		30. Name and address of person who completed cause of death (Item 23a)	Type, Pr						, ====
			Dr. Christopher James Duke, 4550	Mont	gomery Av	enue, S	Suite 733	N, Bet	hesda.	MD 20814
	Stat		31. Date filed (Month, Day, Year) 2. Registrar's Signature	600	w					
	Registra	r	NOV 2 4 2010 /2 . M							

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM/SperFH, G910, 12/22/2010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 22, 2010 Gladys Schwartz 22:20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 064-16-0906 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😡 F 89 Months Days Hours Min. May 1921 NewYork Director 060 07 2470 Usual Residence of Decedent or 28a-f show e notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No Gaithersburg Montgomery 10e. Street and Numbe č 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 15152 Winesap Drive 20878 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. should be filed within 72 hours after or and Merital Hygiene. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 Yes 2X No Specify: Specify: White 3 ☒ Widowed 4 ☐ Divorced Year or Dates Jemit. Page 1 and 2 should be filed within 72 hours Dept. Itment of Health and Mertal Hygiene. Important: If item 27 is marked other than "natur any njury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Dental Hygienist Dental Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Jacob Pluss Pearl Ruda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Marlene Schwartz/Daughter-in-law</u> 15152 Winesap Drive, Gaithersburg, Maryland 20878 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Garden of Remembrance 11/24/2010 4 ☐ Donation 5 ☐ Other (Specify) Clarksburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address Danzansky-Goldberg Memorial Chapels, MO1597 1170 Rockville PIke, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lip. Approximate Interval Between Onset and Death Immediate Cause (Final √h sician/ disease or condition resulting in death) Medical Examiner Sequentially flat conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) Day 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has death? 1 ☐ Yes 2 🕱 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Npatient 2 ER/Outpatient 3 DOA this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 Natural
2 Acciden
3 Suicide 5 Pending Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town. State Medical 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The decided Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated as Certifying Nurs actioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated as Certifying Nurs actioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier Doo62435 1910 1010 Male Cular Dr. Rockville, MD 20850 31. Date filed (Month, Day, Year) State Registrar

SLADYS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2:10рм Michael John Schmidt 2010 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 12812 Gaffney Road Silver Spring 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Gountry) Maryland 1 X M 2 D F Months Days Hours Min. (Month, Day, Year) 01/19/1949 Director 61 217-50-7271 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Silver Spring 1 Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12812 Gaffney Road 20904 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes Give 3 Widowed 4 Divorced Specify: White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Financial Mortgage Banker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be William Schmidt Jeanette Foote 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a Mary V. Schmidt - Spouse 12812 Gaffney Road, Silver Spring, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it ō cemetery, crematory or other place) 5 1 X Burial 2 Cremation 3 Removal from State injury (4 Donation 5 Other (Specify) Lincoln Cemetery : 11/30/2010 Brentwood, Maryland Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Manewar 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician, Bladder Cancer disease or condition uears Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of, ned by the attending physician and detached for use as the المنظمات or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year ☐ Pregnant at time of death ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 X No nin 24 hours after death.

the Funeral Director: After this certificate h
npleted filled in by the funeral director, page 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To 1 🗌 Yes 2 🛛 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 K Residence 6 Other (Specify, 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 2 Accident
3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifie

Cheryl Aylesworth

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

I.D.

egistrar's Signat

D54378

2730 University Blvd. #400, Wheaton, Maryland 20902

29d. Date signed (Month. Dav. Year)

November 22, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 - For State Registrar	State of Maryla	nd / Depa			lental Hyg	•	10	391	าลก
			Decedent's Name (First, Middle,	Last)				2. Date of Dea	th		3. Time of I	Death
	Physici /Medio		Ruth Beckwith	Scott				Month Novembe	er 17, 2	010	9:38	A ^M
	Examir		4a. Facility Name (If not institution,			4b. City, Town, o	r Location of Death		4c. County o			
			Talbot Hospice	House		Easton			Talbot			
	Funeral				s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthplace Country)	e (State or	Foreign
	Director		216-09-4889	1UM 2LAF 94	Yrs.			Feb. 12	,1916	Maryľa	and	
1	and w		Usual Residence of Decedent 10a. State 10b. County	10c, C	ity, Town or Lo	cation				10d.	Inside City	v Limits
h	daryli f aho	ō								100.	1 X Yes	
Y	the 1	Director	Maryland Dorch	ester	Hur1c	10f. Zip Code		1	0g. Citizen of Wi	nat Country	7	
Z	ours after death with the Maryland rai', or itema 23s or 28s-f show Exeminer must be notilied at		202 Oak Street			,	643		USA	-		
de	leath ma 2:	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13. 1			ecify Yes or No-		- American	Indian.	
(0	r ther	표	1 ☐ Never Married 2 ☐ Marrie				lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)		White, etc.		
93	ours a	þ	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1☐ Yes 2∭XNo	Specify:		Specify:	Wh	ite.	
5	72 hours "natural", edical Exe	Completed	15. Decedent's (Specify only highest	Education	16a. Dece	dent's Usual Occup	pation during most of worki	na	16b. Kind of Bus	iness/Indus	try	
21	ithin	d d	Elementary/Secondary (0-12)	College (1-4or 5+)								
2	filed within 72 hours after Hygiene. ither than "natural", or fte ent, the Medical Exemine	S	11		Offic	e Worker			Publish			
n d	9 E 5 ≥	Be	17. Father's Name (First, Middle, L.	,			18. Mother's Name		Maiden Sumame)		
<u>~</u>	should nd Men n marka umatic	မ	Oscar Charles					Harvey				
Ma	d 2 should be filed within 72 hour th and Mental Hygiene. 7 is marked other than "natural treumatic avent, the Medical Ed	19 1	James C. Scott/S				and Number or Rura Road, Hu				,	
<u>ئ</u> _	es 1 and 2 should be of Heelth and Ment fitam 27 is marked rother treumatics		20a. Method of Disposition			sition (Name of natory or other place		-	20c. Location - C			
Baltimore, Maryland 21215-0036	ages nt of t: if it		1 DBurial 2 □ Cremation 3									
量	permit. Page Department Important; if any injury o	1	4 ☐ Donation 5 ☐ Other (Special Signature of Fineral Service Li		-		Cem. 11/21					_
Ba	permit. Departr imports any in	ļi ļ	on and	2011	1 ZE	ller Fun	ss of Facility eral Home treet, Ea	P. 0.	Box 207	MD 214	6 3 1	
			23a. Pand. Enter the disease, or c	omplications that caused the dea	ath. Do not ent	er the mode of dvin	o, such as cardiac o	or respiratory arr	est.	Ap	proximate	
	Dhusisian	0	Immediate Cause (Final	nly one cause on each line.	/	7 /		14	10	Int	erval Betw nset and D	reen
1	Physician /Medical		disease or condition resulting in death)	Due to (or as a conse	116 (ardic	ingope	umy	N:	4	lear	2_
	Examiner			Due to tot as a conse	Av	100.	Nicens	- '		1.	ne n	e*
	1438	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a con	quence of):	4	DISCIO	_		4	eu.	
	be executed sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events	Htheros	clero	tic Co	urdiova	iscula	ur disc	use 1	ica	15
ó	e exemen ar		resulting in death) Last	Due to (or as a conse	quence of):			•		1		
3760,		Ical		d								
Box 68	leath certificat ettending phy I for use as the	Med	IF FEMALE:									
9	ath ce ttend or use	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy	,		23d. Date Mont	of delivery	W.	
	the e	SIC	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown	death 5□	Other (specify)			MORIL	h Day	y re	ear
P.0	The law requires that the death te has been signed by the etter rage 2 should be detached for u	Completed by Physician/Med	Part II. Other significant condition	S contributing to death but not re	sulting in the u	dorhing cause an	on in Part I	23a Did tot	pacco use contrib	vito to the e	auca of do	
Division of Vital Records,	signe d be	d b	Atrial Fib	allation (CRS	inius S	untron	20 1 NO X		Probably		nknown
Ö	v requires been sign should be	ete	malinhalia	Sading	1000	11100	77 1011 011	7				
Rec	has ge 2	ш	111871700116	syriaron	70			24a. Was a autops perforr		ere autopsy or to comple ath?	findings avertion of car	vailable use of
<u> </u>	. 60 -	e Co	25. Was case referred to medical					1 ☐ Yes 2	210 No 15	Yes 2	No	
Ξ		o Be	examiner?	Hospital: 1 Inpatient 2	7 FB/0	Oth	26. Place of Death		No.		1	-
ō	a Phy ar this aral d	$\vdash \downarrow$	27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of	t 3 DOA 28c. Injun Worl	4 Nursing Ho		ow injury occurred	(Specify) /-	jesp.	160
<u>io</u>	Attending r death. ector: Alter by the funer	텵	1 Natural 5 ☐ Pending 2 Accident investiga		Injury		k? Yes 2 ∐No		HE SANGE		,	
<u>vis</u>	Atte or des octo by th	<u>2</u>	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		nome, farm, str	eet, factory, office			reet and Number	or Rural Ro	oute Numb	er,
ā	s effe	Certification:	4 - Homodo	building, etc. (Spec	ily)			City or Towr	i, State)			
	hour hour uner		29a Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best of my kn	uwladge, death	decurred at the tin	ie, datu and place, i	and due to the or	nam bna (e)eeuz	nor as state.	d	
	To the Hospital or Attending Physwithin 24 hours efter death. To the Funeral Director: After this completely filled in by the funeral di	ledical	5,	caminer: On the basis of examinand manner stated.	androrin							
	o to to	Σ	29b. Signature and title of certifier	100.		29c. License		!	9d. Date signed (
			14/1/	MY ATTER	YALA	DOC	5309	1	1/-1	8-0	20/0	\mathcal{L}
	1		30. Name and address of person w	no completed cause of death (Ite	m 23a) (Type,	Print)	53099 ningdai	1. 1.	r-1	. 1.1	21	632
	- 01		31. Date filed (Month, Day Year)	1000 MD		13100m	1/19401	E HVE,	reace	4150	119,11	10
	Sta	τe	31. Date filed (Month, Day, Year)	110 Ze. Hogistiai s Sign	A Section	that	,				_	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Agatha Teresa Stoke1 2010 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Nursing Center Leonardtown St. Mary's 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Missouri . Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 🗆 M 2 🕱 F Months Days Hours Min 0271971922 Director Yrs 88 492-26-1487 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland St. Mary's Leonardtown 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 22730 Duke Street 20650 USA 72 hours after death 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) and 2 should be filed within Health and Mental Hygiene. College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry Boedeker Marv Elizabeth Hengglar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Thomas Stokel, Sr./Spouse injury or other P.O. BOX 39, Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o P cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aloysius 12/01/2010 | Leonardtown, MD Signamus of Funeral Service Censee Laward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset a. d Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the buriarl-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Unknown Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🙆 No 1 Tes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) 2 rune 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. P. Jarboe, 24035 Three Notch Rd., Hollywood, MD 20636 James

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Mo)

32

30

egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For	State of Marylan	d / Depa	artment of F	Health and M	lental Hygic	ene
			1 - State Registrar		Ce	rtificate of	Death	Reg	. No. 2010 39082
- 500			1. Decedent's Name (First, Middle, L	ast)				Date of Death Month	Day Year 3. Time of Death
	Physicia /Medic	20	WILLIAM	C. TILG	HMAN_	SR.			3:00 A M
	Examin	er	4a. Facility Name (If not institution, g			4b. City, Town, o	or Location of Death		4c. County of Death
		-	BAYRIDGE NURS 5. Social Security Number 6.	ING HOME Sex 7. Age (In yrs. I	lo at hirthday	ANNAPOL If Under 1 Year		8. Date of Birth	ANNE ARUNDEL
	Funeral Director		5. 577–78–8750	1X M 2□F 57	Yrs.	Months Days		(Month, Day, Y	
lin.			Usual Residence of Decedent	37				JULY 22	1953 MARYLAND
	ylanc how		10a. State 10b. County	10c. City	y, Town or Lo	ocation			10d. Inside City Limits
	e Mar ta-f si	ctor	MD PRINCE	GEORGE'S CAP	ITOL F	HEIGHTS			1 TYYes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Country?
	be filed within 72 hours after death with the Maryland tat Hygiene. And ther than "natural", or items 23a or 28a-f show dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	rai	5809 JUNIPERTRE				20743		SA
	er de items	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spe oan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
30	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ XDivorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates;		1 ☐ Yes 2¶ No	Specify:		Specify: BLACK
9500-612	2 hou atura cal E	ed	15. Decedent's	Education	16a. Dece	edent's Usual Occup	pation	16	b. Kind of Business/Industry
<u>က</u>	within 72 ene. than "na he Medic	Completed	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	(Give	e kind of work done DO NOT use retire	during most of worki	ing	
_	d with	ا ق	12TH	00/logo (1 40/ 01/)	WA	AREHOUSE	MAN	P	RIVATE
/land	be filed tal Hygi d other event, tl	Be (17. Father's Name (First, Middle, La.	st)			18. Mother's Name	(First, Middle, Ma	iden Surname)
		은	ELMER TILGHMAN				ESTELLE		
	2 sh and is m aum		19a. Informant's Name/Relationship		1				City or Town, State, Zip Code)
ອ໌ ອົ	s 1 and if Health item 27 other tr		JEROME TILGHMA						MARYLAND 20724
	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 XBurial 2 □ Cremation 3	☐Removal from State	emetery, cre	osition (Name of ematory or other pla	ice)		c. Location - City or Town, State
	t. Pa ntmer ntant; njury		4 □ Donation 5 □ Other (Spec						LINTON, MARYLAND
e n	permit. Pages Department of Important: If it any Injury or once.		21. Signature of Funeral Pervice	ensee					NS FUNERAL HOME, INC. LLE, MARYLAND 20785
1			23a Part1 Enter the disease or co	mplications that caused the death					
			23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final						Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consequ		KUIIC CA	RDIOVASCUI	LAK DISEA	SE
	Examiner		4	SEIZI					
3	2%	ĕ	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ	uerice of).				
	ficate be executed I physician and is the burial-transit	Examiner	triat mitiated events	HYPE:	RTENSI	ON			
Ď	exectan an an irial-tr		resulting in death) Last	Due to (or as a consequ	uence of):				
04/8	ate be nysici he bu	dical		d					
٥	death certificate e attending phys d for use as the	- w -	IF FEMALE:						
o n	death certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Fetal	death 3	⊒Ectopic pregnanc	;y		23d. Date of delivery Month Day Year
- -	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5[Other (specify) _			Bay Four
	w requires that the de been signed by the should be detached	Ph	Part II. Other significant conditions	contributing to death but not resu	ulting in the u	ınderiying cause giv	ven in Part I	23e. Did tohac	cco use contribute to the cause of death?
S,	signe d be	l by			3	, . 3 3			2 No 3 Probably 4 Munknown
	v requ	Completed			_			04= 14/== ==	045 Marin de disease de la
a).	The law ate has b	m m						24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
	sician: The law certificate has t irector, page 2 s		25. Was case referred to medical					1□ Yes 2□	
-	Physician: r this certific ral director,	o Be	examiner? 1 Yes 2 XNo	Hospital: 1 ☐ Inpatient 2 ☐	EB/Outpatia	nt 3□ DOA Oth	her:	(Check only one)	0 Flour (0 - 7)
	tending Physeath. tor; After this the funeral di	-	27. Manner of Death	28a. Date of Injury	28b. Time o	III 3 DOA	4 A Nursing Ho	me 5 ⊔ Hesideno 28d. Describe how	ce 6 □Other (Specify) injury occurred
=	Afte fune	흲	1 Natural 5 Pending 2 Accident investigati	on (Month, Day Year)	Injury		rƙ?]Yes 2 □ No		
9		(0)	3 Suicide 6 Could not		ome, farm, st	reet, factory, office		28f. Location (Street	et and Number or Rural Route Number,
N N N	Attending r death. ector: After by the fune	ij	datarmina					City or Town, 3	State)
DIVISION	tal or Atter s after deal al Director ed in by the	Certific		building, etc. (Specify					
DIVISIO	ospital or Atter hours after deal uneral Director sly filled in by the	cal Certification:	4 ☐ Homicide determine 29a. Certifier 1 ☐ Certifying I	Physician: To the best of my kno	wledge, deat	th occurred at the ti	ime, date and place,	and due to the caused at the time.	se(s) and manner as stated.
DIVISIO	the Hospital or Atter in 24 hours after deal the Funeral Director pletely filled in by the	edical	4 Homicide determine 29a. Certifier (Check only one) 1 Certifying I 2 Medical Ex	Physician: To the best of my kno	wledge, deat	th occurred at the tinvestigation, in my	ime, date and place, opinion, death occur	red at the time, date	e and place, and due to the cause(s)
DINISIO	To the Hospital or Attendin Swithin 24 hours after death. To the Funeral Director; Aft completely filled in by the fun		4 Homicide determine 29a. Certifier (Check only 2 Medical Ex	Physician: To the best of my kno aminer: On the basis of examina	wledge, deat	th occurred at the ti	ime, date and place, opinion, death occur	red at the time, date	se(s) and manner as stated. e and place, and due to the cause(s) I. Date signed (Month, Day, Year)
DINISIO	To the Hospital or Atter To the Funeral Director Completely filled in by the	edical	4 Homicide determine 29a. Certifier (Check only one) 1 Certifying I 2 Medical Ex	Physician: To the best of my kno aminer: On the basis of examina	wledge, deat	th occurred at the tinvestigation, in my	ime, date and place, opinion, death occur se number	red at the time, date	e and place, and due to the cause(s)

State Registrar 31. Date filed (Month, Day, Year)
NOV 2 9 2010

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 39083 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month John William Thompson 8:18 2010 November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey House **Baltimore** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)
Washington, 1 ፟፟፟፟ M 2 ☐ F Months Days Hours Min. 212-68-4320 49 Director August Usual Residence of Decedent show : if item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21701 6351 Spring Ridge Parkway, Apt #248 IISA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 🖾 Never Married 2 🗌 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White Specify: 3 Widowed 4 Divorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Law Firm Office Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William B. Thompson Lethia Baldwin and is 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a William B. Thompson / Father 6351 Spring Ridge Pkwy, #248, Frederick, MD 21701 Department of Healt Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Maryland National Memorial Park 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/20/2010 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. a to mea Jano disease or condition Medical resulting in death) Examiner 4 ptoc Esquentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner signed by the attending physician and it be detached for use as the burial-transit MILE Due to (or as a)consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 2 No 4 Nursing Home 5 Residence 6 Nother Beather + hospice 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending work Investigation Could not be □ Accident filled in by the 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier d at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MI November 15, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

フェロト

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thomas Thorowgood November 28 2010 9:37 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 579-44-1785 1**X** M 2 □ F Hours Min. 77 May 1 Day, 1933 Washington, D.C **Director** Yrs Usual Residence of Decedent 28a-f show 10a State 10b. County rral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 21703 10g. Citizen of What Country? Funeral 5688 Pebble Drive within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 Married 1X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 white er than "natural", the Medical Exar 1 ☐ Yes 2 No Specify: Completed 3 Divorced Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Deputy Sheriff law enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be in Department of Heatth and Ments Important: If item 27 is marked William Raymond Thorowgood Martha Garrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Thorowgood - wife 5688 Pebble Drive, Frederick, Maryland 21703 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State injury or 11-29-2010 Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home any sam 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ PULMONAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, reading to minediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on the burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IE EEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day 5 Other (specify) Year Pregnant at time of death Yes 2 No 9 Unknown the be detached g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Pulmonar ? 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No this certificate 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 Yes Certificate: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, completed filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of hours after death. uneral Director: After 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 \square Homicide To the Hospital within 24 hours a To the Funeral L Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier

10+IUA

State

Registrar

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Ye,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Grisson

1475

32, Registrar's Signature

Basina

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

TANGY

DZ1944

AVE #204

29d. Date signed (Month, Day, Year)

FREDERICK

10-09011 Robert L. Tinsley Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

3	1	1	0		0	3	0	
-	U	100	0	Ų.	y	U	d	

		1- For State Registrar Ameno#5, PerFF	IDT 12_3_10~	Certif	icate of I	Death			Reg. No	0.	1 0	00000
Physic	ian/				-			2. Date of I	Death			3. Time of Death
Medical Exam	inei	Robert L.	Tinsley					Month Novem	ber 23,	2010 Year	·	2232 hrs
		4a. Facility Name (if not institution	on, give street and nur	mber)	4b	. City, Town, o	or Location of			c. County o	f Death	
A. Carrier and Car		2334 Glenmont Circle	Apt. 202			Silver Spri	ng			Montgom	nery	
Funeral		Social Security Number	6. Sex	7 Age (In yrs. last I	pirthday)	If Under 1 Ye	ar If Under	24Hrs. 8. Date of	Birth/MN	//DD/YYYY)	g. Birtl	hplace (State or
Director		237=42=4734 243=90=1130	1	56	.,	Months Da		Min			Foreign	Eden, NC
			1X M 2 F		Yrs.			11/2	4/19.	53	Cou	intry)
È	l	Usual Residence of Decedent 10a. State 10b. County		100 City To	wn or Location			_				
w any				, ,								10d. Inside City Limits
Aaryland 28a-f show Lat once,	٥	MD Montg	omery	Silver	Sprin	ıg						1 X Yes 2 No
Aary Aary 1 at c	Director	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of Wha	at Coun	try?
th the Maryland 23a or 28a-f sho notified at once.	ᄒ	2334 Glenmont	Circle Ap	t 202	Į	20902			Uni	ted St	ate	S
with 18 23 re 110	쿕	11. Marital Status	12. Was Dece	edent Ever in U.S.	13. Was	Decedent of H	ispanic Origi	n? (Specify Yes or	No-	14. Race	- Americ	an Indian, Black,
eath item	Funeral	1 X Never Married 2 M			If Yes	, specify Cuba	an, Mexican,	Puerto Rican, etc.)		White,		,,
ter d ", or er m		3 Widowed 4 Div	1 Yes vorced If Yes, Give Year	2X No	1 D V	es 2 X N	o specific			Specify: E	31ac	k
urs af tural	ð.	15. Decedent's Education (Spe	or Dates:			- 11		ind of work done	116h	Kind of Bus		
5-0036 led within 72 hours a Hygiene. other than "natura the Medical Examir	Completed	Elementary/Secondary (0-12)				t of working life			100.	14110 01 000	1110007111	idusa y
36 hin 7 than dica	[호	12	Jones C.	, ,	g 1				_			
l with	0	17. Father's Name (First, Middle	Last)		Salesm	lan	10 Mothorio	Name (First, Middl	P:	rivate	2	-
15 file file file file file file file	Be C	James Adams	Lasty				Anna	Tinsley	e, Maluel	Surname)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o B	19a. Informant's Name/Relations	his (Time Driet)		IGI - N 111 A	11		-			_	
ID 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 77 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	ř	Kenneth Tinsle	v (cousin)	2205 N	orth 0	ak Cou	per or Rural Route N	inota	Sity of Town $V A$	State,	Zip Code) 200
ore, MD ss 1 and 2 sho of Health and If item 27 is		20a. Method of Disposition										
ore, la		1 Burial 2 X Cremation	3 Removal fro	ct-t- crem	atory or other	on (Name of ce place)		Date		Location - 0		
Baltimore, MD 2121 permit. Pages 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,	n I	4 Donation 5 Other S		Fort	Lincol	n Crem	atory	12/6/2010) B ₁	rentwo	od,	MD
alti mit. sartm ports		21. Signature of Fun rvice			22. Nan	ne and Addres	s of Facility	ort in	on	Funer	ali	ome
9 8 8 1	M.	Kela Mos 4						g Rd. I				
Physician		23a. Part I. Enter the disease, or	complications that car	used the death. Do								Approximate Interval
/Medical		failure. List only one cause	on each line.	e intoxi								Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	u.	consequence of):	cacion						_	Death
			h	ionsequence ory.								
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	consequence of):								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	C									
git d	xal	events resulting in death) Last	Due to (or as a c	consequence of):								
, P.O. Box 68760, ires that the death certificate be executed signed by the attending physician and be detached for use as the burial - transi			d									
oe ex ician irial	edical	X UNPENDED	AMENDED 7	,28a-f,	ner ME	0910 1	2/27/	10 TT				
Box 68760, e death certificate be the attending physiced for use as the bun	√/Me	IF FEMALE:	230. II yes, ot	accome of pregnanc	y				23	d. Date of d	elivery	
687 ertifi ding e as t	an/	23b. Was decedent pregnant in the past 12 months?	Live bir	th	2 Fetal	death 3	Ectopic p	pregnancy		Month	Da	y Year
ath o	sici	1 Yes 2 No 9 Unk		nt at time of death	5 Other	(Specify)						ŀ
the de	Physiciar		9 Unknow									
P.O.	by F	Part II. Other significant conditi	ons contributing to	death but not resulti	ng in the und	erlying cause	given in Part		_		_	e cause of death?
sign								1 1	es 2	No 3	Probal	bly 4 🗸 Unknown
Division of Vital Records, tat or Attending Physician: The law requir rs after death. al Director: After this certificate has been seled in by the funeral director, page 2 should t	Completed							24a. Wa				psy findings available
CO e law e has	립								opsy form <u>ed</u> ?		or to cor ath?	npletion of cause of
tal Rectian: The certificate ector, page	ဒ								2 🗸 N	lo 1	Yes	2 No
certi certi	Be	25. Was case referred to medical examiner?	Hoopital:			26.Place		heck only one)				
Lithis al diric	ဥ	1 ✓ Yes 2 No	Hospital: 1 Inp	patient 2 ER/	Outpatient 3	DOA	Other 1	Nursing Home 5	Reside	ence 6 🗸	Other: S	Scene
ing Ph After t funeral		27. Manner of Death	28a. Date of (Month, D	Injury 28b Day,Year)	. Time of Injur	y 28c. Inju	ry at Work?	28d. Describ	e how inj	ury occurred		
on tendi	읥	1 Natural 5 Pend 2 Accident Inves	·		10:15	Dm 1 ,	Yes 2 X N	o unk				
/iSi	ij			of Injury - At home,			ouilding, etc.	28f. Location	(Street-	nd Number	or Rura	Route Number, City 1
Div	Certification:		mined (Specify)	House				Apt 20	State) Z	334 G. ilver	Lenm	ing, MD
Division of Vital Records, P.O. Box 68 the Hospital or Attending Physician: The law requires that the death certifinate the remains after death. The Funeral Director: After this certificate has been signed by the attending the Funeral Director of the funeral director, page 2 should be detached for use as		00- 0-46	ysician: To the best of	of my knowledge de	eath occurred	at the time do	ate and place				 -	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical		niner:On the basis of	examination and/or								
To To To Com	Med	29b. Signature and title of certifie	and manner sta	ted.	_	29c. Licens						
		1 12	4/						1	Date signed	•	· / /
		Janul Sour	hall Mix			O.C.I	W.∟.		Nov	ember 2	4, 201	U
	1	30. Name and addressiperson		of death (Item 23a)		-			100			
	9 9	Pamela E. Southall, M	D Assistant M	edical Examin	er 111 F	enn Stree	t, Baltimo	re, MD 21201				
	ate	31. Date filed (Month, Day Year) UEC 0 2 2010	32. Regi	strars Signature	4							
Regist	rar	UEL U 2 2010	Lenen	B. Mars								ľ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

_arry Daniel Talle	_	1- For State Registrar		ate of Maryla		ertificate o		d Mental		Reg. No	. 20	10 3908
Physiciai Medical Examin		Decedent's Name LARRY DA							2. Date of Month	Day	Year	3. Time of Death 1632 hrs
		4a. Facility Name (i			ımber)	ı	4b. City, Town, or L	Location of De	Novem		4c. County of De	_
		Shady Grov		<u> </u>			Rockville				Montgomer	
Funeral Director		5. Social Security N		6. Sex		. last birthday)	If Under 1 Year Months Days		Min			Birthplace (State or Foreign Country)
		301-60-0 Usual Residence of		1 ∑ M 2 F	33	Yrs	i.		01/.	31/19	977	WV
v any			10b. County		10c. Cit	y, Town or Locat	ion					10d. Inside City Limits
rland -f shov	호	MD	Montg	omery	Gai	thersbu						1 X Yes 2 No
ne Maryland or 28a-f show any fied at once.	Director	10e. Street and Nur 14530 Jo		n o			10f. Zip Code				itizen of What C	Country?
with th	<u>न</u>	11. Marital Status	nes La		edent Ever in I	U.S. 13. Wa	20878 s Decedent of Hisp	panic Origin?	Specify Yes or	USZ No-		nerican Indian, Black,
death or iten	Fune	1 X Never Marrie	ed 2 M	Armed F	orces?		es, specify Cuban,	Mexican, Pue			White, etc	
rs after rral",	۵	3 Widowed		orced If Yes, Give Yea or Dates: cify only highest grad		1	Yes 2 X No			Lea		Black
72 hour	eted	Elementary/Seco		College (1			t's Usual Occupation ost of working life. I			16b.	Kind of Busine	ss/Industry
vithin one ene.	Completed			1		Conduc	tor			K∈	eolis Ra	ail Services
21215-0036 Mid be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once	န္တ	17. Father's Name (Larry R.			_				me (First, Midd Deerir			
212 ould be Mente mark ic even		19a. Informant's Na		<u> </u>		19b. Mailing	Address (Street			_		ate, Zip Code)
e, MD 21215-003 I and 2 should be filed with Health and Mental Hygiene, item 27 is marked other if reaumarked other if	1			g-Jackson			3 11th Av					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-7 she injury or other traumatic event, the Medical Examiner must be notified at once	1	20a. Method of Disp 1 X Burial 2		3 Removal fr	om State	crematory or oth		,	Date		Location - City	
Itim it. Pag rtment ortant: y or o	-	4 Donation 5 21. Sign Fire of Fur	Other Sp	ecify:	Br	cooke Gr			_/26/10			lle, MD
Ba perm Depa Impe	ļ	Len	rar	KK	nauce	h 24	ame and Address of N. Wash	ingtor	snowden 1 St, Ro	rune ckvi	eral Hon .lle, MI	ne D 20850
Physician	1	23a. Part I. Enter the failure. List only	disease, or	complications that ca	used the deat							Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (F		Multiple Inju	_	- D:	·				·	Death
	1	Sequentially list con		Due to (or as a b.	consequence	or):						·
	liner	if any, leading to importance. Enter Under	mediate lying Cause	Due to (or as a	consequence	of):						
red Insit	Exam	(Disease of injury to events resulting in d		Due to (or as a	consequence	of):						
6 be executed ysician and burial - transit	edicar	UNPENDED		d AMENDED								
760, Icate be physici the buri	Me	IF FEMALE: 3b. Was decedent p	regnant in th		utcome of preg	_		7_		23	d. Date of deliv	ery
Box 6876 e death certificate the attending phy ed for use as the l	Sign	past 12 months?		Live b	rth ant at time of de	ooth -	aldeath 3 _ er (Specify)	_Ectopic preg	nancy		Month	Day Year
). Box 6876 the death certificate by the attending phycheled for use as the Dhyseirian/M	ŠĹ.	1 Yes 2 N		9 Unkno								
P.C	3	Part II. Other signifi	cant conditi	ons contributing to	death but not r	resulting in the u	nderlying cause give	en in Part I.		_		to the cause of death?
Records, The law require, freate has been sig. page 2 should be	313			 					24a. W	as an	24b. Were	autopsy findings available
Division of Vital Records, tal or Attending Physician: The law requints all and detail. In Director: After this certificate has been silted in by the funeral director, page 2 should be artification: To Re Commissional				•.					pe	topsy formed? s 2 N	death'	
	D :	25. Was case referre	ed to medical					f Death (Che		5 2		Yes 2 No
F Vita	2	1 ✓ Yes 2	No			ER/Outpatient			sing Home 5	Reside		ner:
nding Ph. th. : After tl	5	27. Manner of Death 1 Natural	5 Pendi	28a. Date of (Month, Nov 21,	of Injury Day Year) 2010	28b. Time of In 1531 hrs		at Work? s 2 ✔ No	28d. Describ Motorcycli			
/iSic	<u> </u>	2 Accident 3 Suicide	Invest	igation	of Injury - At h	ome, farm, stree	t, factory, office buil		28f. Location	(Street a	and Number or I	Rural Route Number, City
Division o Hospital or Attending 24 hours after death. Funeral Director: Aftered filled in by the function of		4 Homicide	deter		Major Roa	d / Highway			or Town Mateny Rd		t Seneca High	nway, Germantown, MD
		29a, Certifier 1 Concept one)	ertifying Ph	vsician: To the best liner:On the basis o	of my knowled f examination a	ge, death occurr	ed at the time, date	and place, a	nd due to the ca	use(s) ar	nd manner as st	ated.
		29b. Sign ture and ti		and manner st	ated.		29c. License n		a di tric time, da			fonth, Day, Year)
8		1/1	1. le	un			O.C.M.	E.			ember 22,	
	3	30. Name and address	•	vho completed cause		•						· · · · · · · · · · · · · · · · · · ·
CACA	ء م	Laron Locke		sistant Medical	Examiner		Street, Baltimo	ore, MD 21	201			
State Registra	e s Ir	31. Date filed (Month	1242	010	distrar's Signat	for						

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours a

> Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

KOLLI

31. Date filed (Month, Day, Year,

aurem

2195

32. Registrar's Signature

29c. License number

WASHINGTON

D0066441

STREET

29d. Date signed (Month, Day, Year)

NOVEMBER 17 2010

EASTON, MD

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMESH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Pear 2010 HARRY EARL TAYLOR ovember Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Adventist Hospital Grove Rockville Mont Tomer 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 D F Months Hours 08/02/1915 Country) 95 578-30-5672 TLUsual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits GAITHERSBURG MD MONTGOMERY 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 201 RUSSELL AVE., #333 20877 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 1943 If Yes, Give Year or Dates. 1946 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Dever Married 2 Married þ 1 ☐ Yes 2 ☑ No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) DEPARTMENT OF Elementary/Seconday (0-12) College (1-4 or 5+) TRANSPORTATION AUDITOR 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 HARRY TAYLOR BERTHA LUCAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, MARTHA DZIOBA / DAUGHTER 2124 ROYAL PINES DR., NEW BERN, NC 28560 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State EVERGREEN CEMETERY 11/29/2010 MOOSUP, CT 4 Donation 5 Other (Specify) 21. Signatura of unera 💝 rvir e Licensee 22. Name and Address of Facility P.O. BOX 86 de HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death neuman disease or condition resulting in death) Due to (r as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) Vear 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🖔 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Tyes 2 A No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 Yes 2 No

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 signed by has this certificate Hospital or Attending Physician: within 24 hours a

052

01/20/11

Baltimore, Maryland 21215-0036

Funeral

Director

28a-f shov

ō

 23 a

items

ō

and Mental Hygiene. is marked other than "natural",

Important: If item 27

Ph sician/

Medical

Examiner

of

injury or other

any inj

traumatic event, the Medical

Examiner must be notified at

the attending physician and the for use as the burial-tran Physician/Medical Completed by eral Director: After this certific filled in by the funeral director, Certificate: To Be Medical

Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 20a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Rockville, MD20850

29c. License number Doo 62435 29b. Signature and title of certifier

empleted cause of death (Item 23a) (Type, Print)

0

State Registrar

15+ 1 VA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year verne 2:01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City **Examiner** 4c. County of Death Town, or Location of Death inton reorg e If Under 1 Year 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F Days Hours Min **Director** Yrs. Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 ☐ No 10e. Street and Number ь 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a o Examiner must be Funeral 20746 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 7 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ury or other traumatic event, the Mr Elementary/Seconday (0-12) Coflege (1-4 or 5+) Governme er Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ man 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or I Route Number, City or Town, Sta e, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If i any injury or o 1 Burial 2 Cremation 3 Removal from State 12 4 Donation 5 Other (Specify) 3 2010 Alexandria permit. 22. Name and Ad ress of Facility Phill, LNNSON F.A. 1018. DUNKINK, M. 36 Bell Sr. & Winona Southern M. 21. Signature of Funeral Service Licensee Mossissette Bells southern Maryland Bud 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final 4 Onset and Death 5 Physician/ SIN disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner U75 277 Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (of as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day this certificate has been signed by the ral director, page 2 should be detached 1 ☐ Yes 2 x 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending in 24 hours after deau...
ihe Funeral Director: Aft 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical THE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 23

Registrar DHMH 17 Rev 7/2009

State

Date filed (Month, Day,

NOV 28 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

667022 Physician /Medical Examiner Funeral **Director** permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, ITe Madical Examination in experiment be rediffed at once. Judith A. Wagner 1424/1943 To Be Completed by Funeral Director Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1 - State Registrar	,	Cei	rtificate of	Death	Rec	g. No.	
1. Decedent's Name (First, Middle, La	ast)		-		2. Date of Death Month		3. Time of Death
JUDITH A. WAGNE	R				NOVEMBER	. 20, 2010	10:57 A ^M
4a. Facility Name (If not institution, give	ve street and number)			or Location of Death		4c. County of Deal	
FENWICK INN 5. Social Security Number 6. 8	Sex 7, Age (In vr	s. last birthday)	OCEAN If Under 1 Year		8. Date of Birth	WORCE	
	1 □ M 2 🖾 F 66	Yrs.	Months Days	Hours Min.	(Month, Day,) 12-24-19	<i>Year) C</i> o	thplace (State or Foreign buntry) RYLAND
10a. State 10b. County	10c. C	City, Town or Lo	cation		_		10d. Inside City Limits
MARYLAND WORCES	TER	OCEAN (1x Yes 2□No
10e. Street and Number 17 E. 70TH STREE	T UNIT 16		10f. Zip Code	342	100	g. Citizen of What Co US	untry?
11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of I f Yes, specify Cub 1 □Yes 2 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
15. Decedent's Ea (Specify only highest gra	ade completed)	I (Give	dent's Usual Occu kind of work done DO NOT use retire	during most of work	ing 16	6b. Kind of Business/	Industry
Elementary/Secondary (0-12)	College (1-4or 5+)			CROSSING	GUARD C	ITY GOVER	MENT
17. Father's Name (First, Middle, Last, JACQUE GEORGE AY)	•				e (First, Middle, Ma	•	
19a. Informant's Name/Relationship (10h 14-0	a Address (Ot		SABELLE		T'- O-d-)
SEAN CAUFFMAN-DA						City or Town, State, 2 A, MD. 21	
20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	Removal from State	Place of Dispos cemetery, cren		ce)	Date 20	RANKFORD	Town, State
21. Signature of Funeral Service Licer		MÎ 43	ELSON FUN R THATCHE	TERAL SERVER ST. FRA	VICES, LTD	DF 100/5	
23a. Part 1. Enter the di ease, or com shock, or heart falure. List only	plications that caused the dea						Approximate Interval Between
Immediate Cause (Fir al disease or condition	a pessible	Compli	cation	of Diche	tes		Onset and Death
resulting in death)	ue to (or as a conse	quence of):					
Sequentially list conditions, if any, leading to immediate	b Due to (or as a conse	quence of):					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		4.0					
resulting in death) Last	Due to (or as a conse	quence of):		 -			
	d			.			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of	al death 3 🗆	Ectopic pregnanc	y	AV (*	23d. Date of deli	very Day Year
1 □Yes 2 ☑No 9 □ Unknown	9 Unknown	deam 5	Other (specify) _				ŕ
Part II. Other significant conditions o	ontributing to death but not re-	sulting in the un	derlying cause giv	en in Part I.		cco use contribute to	the cause of death?
					1		
					24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of 2 🗆 No
25. Was case referred to medical examiner?	Hospital:		Oth		(Check only one)		
1 Yes 2 □ No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatient 28b. Time of		4 LI Nuising Ho	me 5 Residence 28d. Describe how	oe 6 Other (Specialistics)	ity) in hotel
Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	28c. Injur Wor M 1	Yes 2 □ No	zou. Describe now	injury occurred	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
29a. Certifler (Check only one)	nysician: To the best of my kniner: On the basis of examinand manner stated.	owledge, death ation and/or inv	occurred at the ti estigation, in my o	me, date and place, ppinion, death occurr	and due to the cau red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
29b. Signature and title of certifier			29c. Licens			. Date signed (Month	
16/1	M.D.		D	solder 2	٥	11/22/2	010
30. Name and address of person who of AhF Zeeshaw	completed cause of death (Itel	m 23a) (Type, F	Print)	Bellin N	10 2181	l	
31. Date filed (Month, Pay, Yar) 3 2	010 32. Fegistrar's Signa		es Ked				

DHMH 17 Rev 1/2001

State

Registrar

Dri 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 391192 Certificate of Death Reg. Nov-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DECEMBER T 201 Ôar LOUISE THELMA WILSON 12:38р м /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Chestertown Nursing & Rehab Kent Chestertown 7. Age (In yrs. last birthday) 94 vre If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Jan 3, 1916 **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🛭 F Months Days Hours Min Mary land Director 218-07-2506 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b, County 10c. City, Town or Location ral", or items 23a or 28a-f show 10d. Inside City Limits Director MD Kent Chestertown 1XIYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 Morgnec Rd. Apt. N 102 21620 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐Yes 2 No δ Specify. Specify: "natural", 3₺ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Ir. Elementary/Secondary (0-12) College (1-4or 5+) Line Supervisor 8 Food Processing 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Nathaniel Brown 2 Edith Knox 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia W. Moffett (daughter) 101 Morgnec Rd. Apt N 102 Chestertown, MD. 21620 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Chester Cemetery 12/7/10 Chestertown, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Galena Funeral Home of Stephen L. Sc 118 West Cross St. Galena, MD. 21635 M00510 lart 1. Inter the o sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or result tory arrest, slick, or heart failure. List only one cause on each fline. Approximate Interval Between Onset and Death Immediate Cau e (Final disease or condition resulting in death) terio schero Physician Dears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 20 No 3 ☐ Probably 4 ☐ Unknown Completed Was a autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this l ann Death After t 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation within 24 hours are: working the Funeral Director: A' 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10017036 (500 MU) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 516 Washington Ave. Susan K. Ross, M.D. Chestertown, MD. 21620 32. Registrar's Signature 31. Date filed (Month, Day, Year) State park Registrar

DHMH 17 Rev 1/2001

Registrar

State

Baltimore, Maryland 21215-0036

Box 68760

P.O. I

Records,

Division of Vital

20832

Vladimir Rakhmanin / 18101 Prince Philip Dr./ Olney, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30

31. Date filed (Month, Day, Year)

ċ				Please	Type or Pri								_	le.		
_			For State		State of M	arylan		ırtment of <i>tificate of</i>			ental Hy	_	00:	0	200	0.1
5			Registrar 1. Decedent's Name	e (First, Middle, La	st),		Cer	uncate or	Deair	— т	2. Date of De	Reg. N	0,	4	3. Time of D	9 L
	Physicia Medi		Davic	1 Kent	Whar	10	<u> </u>				Month	Der.	3 8,2ŏ	ear NO	11:45	PM
ゴ	Examir	ner	4a. Facility Name (if	not institution, give	e street and number)	Sus	stem	4b City, Town,	or Locatio	on of Death		1	County of	Death		
KELTOI)	Funeral Director		5. Social Security N	1	Sex 7. Ag ▼ M 2 □ F		79 Yrs.	If Under 1 Yea Months Days			8. Date of Bir (Month, Da 04/20		1 N	Birthpla Country [ary]	ce (State or F	oreign
♀.			214-28-12 Usual Residence of 10a. State				, Town or Loc	ration			04/20/	193	<u> </u>		. Inside City	Limite
3	/arylan 8a-f sh tified a	recto	MD	Kent			lena	allon						100	1 Yes 2	
7	permit. Page 1 and 2 should be filed within 72 hours attar death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Nun	nber				10f. Zip Code				10g. C	itizen of Wha	at Country	?	
j	ath wi	nue	34275 De 3	Laware Li	ne Road 12. Was Decedent B	ever in 115	13. V	216. Vas Decedent of		Origin? (Spec	ifv Yes or No-		14. Race -	American	Indian	
SICHOLO.	or ite	by F		ied 2X Married	Armed Forces?		l II	Yes, specify Cul	oan, Mexic	can, Puerto R	ican, etc.)		Black,	White, etc		
NCC SCC SCC SCC SCC SCC SCC SCC SCC SCC	tural"	ted	3 🗌 Widowed		If Yes, Give Year or Dates.	1951-	52	☐ Yes 2XIN		my:			Specify:		ite	
五	72 hc	Completed		15. Decedent's E	rade completed)		(Give I	ent's Usual Occu ind of work done O NOT use retired	during m	ost of working	g	16b.	Kind of Busir	ness Indus	stry	
2)8	within giene.		Elementary/Seco		College (1-4 or 5	o+)	Indus	trial R	élati	lons Ma	anager	E1	ectri	cal C	ontrol	ls
$\frac{1}{2}$	2 should be filed the and Mental Hy 27 is marked oth traumatic event	To Be	17. Father's Name (I						1		(First, Middle, Lzabetl		,			
٢ -	ould bould bound mark		Walter G: 19a. Informant's Na				19b Mailin	g Address (Stree						e. Zip Coo	ie)	
- 1	d 2 sh d 2 sh salth ar salth ar salth ar sertrau		Linda Wha					Delawa								
	or officer and or officer and		20a. Method of Disp	position	Removal from State		lace of Dispo emetery, cren	sition (Name of natory or other pl	ace)	1	ate	1	Location - Ci	•		
	Definition of permit. Page 1 and Department of Her Important: If item any injury or other once.		4 ☐ Donation 21. Signature of Fur	5 Other (Speci	**	Mi1		n-Asbur			/2010		lling			
ء لح	Dep Dep Onco		1 Long	fellows	/		Fi 13	Name and Addi CLLOWS, O SPEER	HELFE ROAI	ENEBIN CHES	& NEW TERTOW	NAM N, M	FUNERA IARYLAI	AL HC	ME, P. 620	. A
CHIL			shock, or hear	rt failure. List only o	plications that caused one cause on each line	d the death e.	n. Do not ente	r the mode of dy	ing, such a	as cardiac or	respiratory a	rrest,		lr Ir	pproximate iterval Betwe	
=	Physician/ Medical	ı	Immediate Cause (disease or conditio resulting in death)		a. Que to (or as	201	<u> </u>							<u> W</u>	nma	<u> </u>
	Examiner		Comment of the second	- dia:	Hupe	rte	NSID	n						ur	ma	S
	sit sit	Examiner	Sequentially list configure to im- cause. Enter Under Cause (Disease or	nmediate rlying	Dua for as	a consequ	ence of:	2 1 1,4	15	Tun	2				okna	w
	executed an and nal-transit		that initiated events resulting in death) I	s	C. Due to (or as	a consequ	ence of):	١١١١١		1912					שאחי	<u> </u>
Ş		dical			d									+		
1	Sertifica Iding p	J/Me	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome	of pregna	ncy					Ţ	23d. Date of	of delivery		
	death death of atter	Physician/Medic	in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown			Ectopic pregna Other (specify)	ncy				Month			ar
	requires that the de been signed by the should be detached				contributing to death b	ut not res	ulting in the u	nderlying cause	given in Pa	art I.	23e. Did t	tobacco	use contribu	te to the	cause of deat	th?
-	quires t quires t en sign uld be	Completed by	Coron	aryh	irtery 1	Jis	ease				1 🗆	Yes 2	2 □ No 3	Probab	oly 4 Un	iknown
	law rec	nple							-	-	24a. Was	psy	prio	r to comp	findings ava letion of cau	ilable se of
	hysician: The law his certificate has to director, page 2 s		25. Was case referre	ed to medical				26	Place of D	eath (Check		2 V	io 1	Yes 2	Z No	
1	ysicia ysicia is certi	To Be	examiner?	A .	Hospital:	ent 2 \square	ER/Outpatien				ne 5 Resi	dence	6 Other (Specify)		
4	ling Ph		27. Manner of Death	h 5 🗌 Pending	28a. Date of inju (Month, Day	ry y, Year)	28b. Time of injury		ury at rk?	28	8d, Describe					
	al or Attending Physis after death. I Director: After this c	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigatio 6 Could not be determined	28e. Place of Inju				Yes 2		8f. Location (r Rural Ro	oute Number,	,
	urs afte				building, etc					8	City or Tov					
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	(Check 2	☐ Medical Exam	rsician: To the best of niner: On the basis of e se Practioner: To the	xamination	and/or invest	igation, in my opii	nion, death	occurred at t	he time, date	and plac	e, and due to	the cause	(s) and manne	er stated.
	To the To the Comp	[29b. Signature and		-11 - 0			29c. Licen					ate signed (A			
	10		She	794	Pash	mi	ML	1 00	146	48		10	remb	u'd	4,201	0
	Rm		SW Marke and address	35 of person who	completed cause of d	eath (Item	rular	Treas	14h(are ?	iuskr	nA	erruf	Paint	mp:	4906
	Sta Registr		31. Date filed (Monti	NOV 3 U	2010 32. Registra	ar's Signat	A. A	back			<u></u>	,	0		,	
	TEGISU	2.1	4			-	, (1									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended #1, 11/23/10, RM, Kent Castate of Maryland / Department of Health and Mental Hygiene Amended #17, 1 = State#19b, 22 11/19/10 M.S. Kent Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20°4°0 9:25A Doris Watson Anna Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Corsica Hills Nursing Home Centreville Oueen Anne's 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🖵 F Months Days Hours Min. 0491122 /91919 217-42-5660 OUSA Director 90 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "notice." 10a. State 10h Counts 10c. City. Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Queen Anne's Centreville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3014 Church Hill RD 21617 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces à 1 Never Married 2 Married Black, White, etc. 1 Yes 2 No Speciallack 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates X 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>House Keeper</u> Private Family Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Andrew Pritchett Pritchett Mary Lena Bonds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3008 Church Hill RD (centrevoille, M) William Hollis 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State hesterfield Cementery 11/23/10 4 ☐ Donation 5 ☐ Other (Specify) Centreville, MD 21. Signature of Funeral Service Lin 22. Name and Address of Facility Bennie Smith Funeral Home BBCheste 21620 25a. Part 1. Enter the disease, or complications that ne death. Do not enter the mode of dying, such as cardiac or Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** TRANS Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day 1 Yes 2 Unknown be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy eral Director: After this certificate I filled in by the funeral director, page perform Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital: Other: ' မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1. Natural 5 Pending after death. 2 Accident
3 Suicide Investigation M 1 Yes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \square Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Hern 23a) (Type, Print) 610V 31. Date filed (Month, D State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** Son November 23 2010 12:30a vetta /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Easton
Vear [If Under 24 Hrs. Genesis Health Care-The Pines Talbot Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
June 3. 1922 Social Security Number **Funeral** -18-7289 1 □ M 2 🖫 F Months Hours Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it will deal Experiment: 181 by notified 31 once. 1 PYes 2 □ No Cambridge Director Dorchester 10g. Citizen of What Country? 10e. Street and Number 5 A 1613 MSon Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Mary Wand 29215-0036 1 ☐ Yes 2 PNo Black If Yes, Give Year or Dates: Specify Specify Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electron: or Ker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stanlei Mildre 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cambridge 20c. Location - City or Town, State 20b. Place of Dispos cemetery, crem osition (Name of ematory or other p Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/27 New Revived Cemetery 10 4 Donation 5 Other (Specify) Taylors 22. Name and Address of Facility Signature of Funeral Service Licenses Home, P.A Funeral Henry Funeral Stowashington Sti Cam Approximate Interval Between Onset and Death 23a. Palm . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final FAILURE TO THEIVE DNOTE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner VASCULA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-transit OROWARI Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) P.O. within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the sompletely filled in by the funeral director, page 2 should be detached for 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: Hospital: 1 | Yes 2 | XX 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Pursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 🗫 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 1 within 2 To the 1 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIDE QID DUTCHMANT CANE EASTON RIDZIGO 31. Date filed (Month, Day, Year) State NOV 29 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 24, Nov. 2010 7:50 A Sharon Diane Wentzell /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Brunswick 4 West Potomac Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1951 West . Virginia Sept 4, Director 59 212-62-3952 Usual Residence of Decedent filed within 72 hours atter deeth with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State r than "natural", or iteme 23a or 28a-f ehow the Mudical Examinar must be notified at 1X□Yes 2□No Director Brunswick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21716 4 West Potomac Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ō 1 ☐ Yes 2 ☐ XNo Baltimore, Maryland 21215-0036 Specify: þ White 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Waitress 10 and Mental Hygi 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Mabel Loretta Deener Levin West Tribby ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 ie any injury or other trav once. Stacy Taylor - Daughter
20a. Method of Disposition 619 6th Avenue Brunswick, MD 21716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐YBurial 2 ☐ Cremation 3 ☐ Removal from State Brownsville, MD 11/29/2010 4 ☐Donation 5 ☐ Other (Specify) Brownsville Heights 22. Name and Address of Facility Eackles-Spencer & Norton Funeral 21. Signature of Funeral Service Licensee M00970 Home Harpers Ferry, WV 25425 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Exacerbation of Chronic Obstructive Pulmonary Pisease **Physician** ears resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine nding physicien and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Medical Certification; To Be Completed by Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day in the past 12 months?
1 Yes 2 No
9 Unknown 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown heumonia Obstructive sleep aprica 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? and thrombo cytopenia, tobacco use 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 1 Nes 2 No 28c. Injury at Work? filled in by the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of efter death. 27. Manner of Death Injury 5 Pending 1 Xlatural 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital c within 24 hours of To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29h Signature and title of certifier 11/26/20/0 +7169 11 CHAN-HING HO, MID. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bruns wick MD 21711 32. Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Mar				Mental Hy	giene			
			Registrar	Cer	tificate of L	Death		Reg. No.	39098		
	Physicia	an/	1. Decedent's Name (First, Middle, Last) David M				Date of Dea Month		3. Time of Death		
-	Medi Examir		David M. 4a. Facility Name (if not institution, give street and number)		Wilso 4b. City, Town, or		111/17		10:45a [™]		
	LAGIIII	ici	Ft.Washington Health & F	Pahah	Ft.Wash		ın	4c. County of Death Prince George			
	Funeral	1	5. Social Security Number 6. Sex 7. Age (Ir	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs		h 9. Birthi	olace (State or Foreign		
	Director		213-82-2754 1 DXM 2 DF 47	Yrs.	Months Days	Hours Min	11/21	(.Year) Cour	yland		
	ind thow at	۱,	Usual Residence of Decedent 10a. State 10b. County 10	Oc. City, Town or Loc	cation			1.	0d. Inside City Limits		
	faryla 8a-f s tified	Funeral Director	Mary Prince George	Upper M					1 ¥ Yes 2 □ No		
	the h	قَا	10e. Street and Number	opper m	10f. Zip Code		1	10g. Citizen of What Cour			
	s 232 nust b	Jera	7314 Aquinas Ave		20772			USA	,		
	death item ner n		11. Marital Status 12. Was Decedent Ever	in U.S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (S	pecify Yes or No-	14. Race - Americ			
36	after al", or xami	d by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	1	Yes 2 KNo		o riiodii, cto.j	Black, White,			
9	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed by	Year or Dates. 15. Decedent's Education	16a Deced	ent's Usual Occupa	tion		Bla			
215	n 72 l e. an "r Med	dmo	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give k	rind of work done do NOT use retired)	uring most of wo	rking	16b. Kind of Business Inc	dustry		
7	within /giene.		1 2		echanic			Autom	otive		
nd	be filed within 72 hours after death with the Maryland ental Hygiene. rked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, I				
<u>₹</u>	should be fil and Mental is marked aumatic ev	-	Joseph	Wilson		Mildre					
Ma	ge 1 and 2 should be it of Health and Men If Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type, Print)					City or Town, State, Zip C			
ઈ	and Heal tem tem		Mildred Harper/Mother 20a. Method of Disposition	7 3 7 4 20b. Place of Dispos		Ave U		rlboro MD			
Baltimore, Maryland 21215-0036	permit. Page 1 Department of 1 Important: If it any injury or or once.		1 Burial 2X Cremation 3 Removal from State	cemetery, crem	atory or other place		Date	20c. Location - City or To			
≡	mit. P partm portai / injur		21. Signature of Funeral Service Licensee	Metropol	Name and Address		23/10 P	lexandria	, Va		
Ä	permi Depar Impo any ir once,		Therea Neal			,	omePa A	quasco MD	20609		
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not enter	the mode of dying	, such as cardiac	or respiratory arre	est,	Approximate		
	hysician/	1	the state of the s	icer of	the LA.	YNY			Interval Between Onset and Death		
	Medical Examiner		resulting in death) Due to (or as a column as a colum	nsequence of):		- '					
		ər	Sequentially list conditions, b.								
	ed isit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	isequence oi).							
	xecut	Еха	that initiated events resulting in death) Last C. Due to (or as a con	nsequence of):							
9	ate be executed ohysician and the burial-transit	dical									
376	death certificate be executed the attending physician and ed for use as the burial-transit	Ned	u								
ĕ	eath certifica attending p	an/I	F FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of programs 1		Ectopic pregnancy			23d. Date of delive	ry		
P.O. Box 687	death	Physician/Me	in the past 12 months?		Other (specify)			Month	Day Year		
o i	es that the der signed by the s I be detached		Part II. Other significant conditions contributing to death but no	at reculting in the un	derlidae equa eius	e le Dest I					
ω̈́.	res th signe	d by	Superior Sup	resulting in the dir	denying cause give	ii iii Faiti.		pacco use contribute to the			
ğ	requi been should	ete						es 2 No 3 Prob	<u> </u>		
Division of Vital Records,	e law e has ge 2 :	Completed					24a. Was ar autops perforr	y prior to con	sy findings available opletion of cause of		
<u>~</u>	sician: The law certificate has lirector, page 2 s	Be C	25. Was case referred to medical		26 Plac	o of Dooth (Cho	1 🗆 Yes 2		2 🗆 No		
₹ ₹	ysicia is cert direct	To B	examiner? 1 Yes 2 Yoo Hospital: 1 Inpatient	2 ER/Outpatient	Other	e of Death (Chec		2 7 24 7 7 7 7			
o i	neral		27. Manner of Death 28a. Date of injury	28b. Time of	28c. Injury a		28d. Describe ho	nce 6 Other (Specify) w injury occurred			
o	tendil leath. or: Af the fu	Certificate:	1 Natural 5 Pending (Month, Day, Year 2 Accident Investigation 3 Suicide 6 Could not be	") Injury	M 1 □ Y	es 2 🗆 No					
VIS	or Att	Sert	4 Homicide determined 28e. Place of Injury - A building, etc. (Sp		t, factory, office		28f. Location (Str City or Town,	eet and Number or Rural I State)	Route Number,		
	eral C		29a. Certifier 1 Certifying Physician: To the best of my k					,	33		
-	e Hos 124 hr e Fun leted	Medical	(Check 2 Medical Examiner On the basis of examiner	nation and/or investio	ation in my opinion	death occurred a	at the time date and	d place and due to the sour			
ļ	To the Insoptial or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.			or my knowledge, dea	29c. License r	umber	ce, and due to the	cause(s) and manner as stated. Od. Date signed (Month D	ed. av. Year)		
			Will Clu		7350	26		UNunka 17.	2010		
	NBZ		30. Name and address of person who completed cause of death	(Item 23a) (Type, Prir	nt)	Ronl	Fatur	18We with M	1 Day Inc		
	State Registra	e r	30. Name and laptdress of person who completed cause of death which the transfer of the second secon	ignature	arkel	,			11-7/100		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Donald White 2:00 P M Medical 2010 November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 30001 Ronald Drive Mechanicsville St. Mary's 5. Social Security Number Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min. **Director** 404-34-2931 81 Yrs. March 23. 1929 Kentucky Usual Residence of Decedent 28a-f shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits notified Maryland St. Mary's Mechanicsville 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be 10g. Citizen of What Country? Funeral 30001 Ronald Drive 20659 United States 12. Was Decedent Ever in U.S.
Asyned Forces?
1 ⚠ Yes 2 ☐ No
If Yes, Give
Year or Dates. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Government Building Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Frank A. White Georgia Wickline Department of Health and I Important: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Al White/Son 6655 Horseshoe Drive, La Plata, MD 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Charles Memorial Garden 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Leonardtown, MD 21. Signalu e 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., any 30195 Three Notch Rd., Charlotte Hall, MD 20622 MO0817 23a. Part 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition un CA Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and tra Due to (or as a consequence of) resulting in death) Last nding physician are as the burialburial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day the 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform Yes 2 12 the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 🗌 Yes Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Watural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury 1 🗆 Yes 2 Accident
3 Suicide Investigation 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 120 D62042

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

N

istrar's Signature

03

NOV

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Amend #6, per FH, FCHD, 11/29/1© Certificate of Death LE 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Gail L. Zickafoose November 5:04 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10941 Sasha Blvd. Washington Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan • 19 • 1951 **Funeral** 9. Birthplace (State or Foreign **⊤**X M 2 X F Months Director 217-58-0817 Mary Land 59 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at one. 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Washington Maryland Hagerstown 1 🗆 Yes 2 🄀 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10941 Sasha Blvd. by Funeral 21742 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 ☐ No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify. Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Vice President Elementary/Seconday (0-12) College (1-4 or 5+) Commercial Lending Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Agnes Peacock George E. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David C. Zickafoose / Husband 10941 Sasha Blvd., Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven 11/24/2010 Glen Burnie, Maryland 21. Signature of Funeral Service Licens Stauffer Funeral Home 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1, Enter the disease, or complications that saked the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death proust disease or condition curre Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any macing time, discusse. Enter Underlying Cause (Disease or iinjury that initiated events Examiner bun to (or as a donsequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Dav Year the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ P Completed After this certificate has been si funeral director, page 2 should 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 🗌 No 1 🗆 Yes Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident Investigation 1 Yes 2 🗆 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title 29c. License number

State Registrar 30. Name and address of person

Durig

30

Ruseber

rho completed cause of death (Item 23a) (Type, Print

227

trar's Signature

5+

D4082A

Bultimore

Place

M122 2010

21202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2010 Physician/ December 5:40 A^M NELLTE IRENE ALLEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8925 Twelve Sons Court Jessup Howard 8. Date of Birth (Month, Day, Ye Mar • 30, 9. Birthplace (State or Foreign Country) Virginia Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Min. Hours 219-30-1256 76 Yrs. Director I Isual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland at Director r 28a-f sl notified 1 Yes 2 No MD Howard Jessup 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? ö Examiner must be Funeral 23a 8925 Twelve Sons Court 20794 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ĀNo Specify: If Yes, Give Specify: White "natural" Completed 3 XXidowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. i other than " Elementary/Seconday (0-12)
Grade 12 College (1-4 or 5+) Homemaker Own Home event, Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental h ഉ (unknown) Mary Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Sharon Lerette daughter Maryland 20794 8925 Twelve Sons Court Jessup, or other tem 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln Cemetery 12/10/2010 Brentwood, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue, Laurel, 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. Lis only one cause on each line Immediate Cause (Final Physician/ disease or condition Metastatic Lung Cancer months Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury the burial-trans that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown be detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of death? page 2 24 hours after death. Funeral Director: After this certificate 1 Yes 2 **XX**0 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 Yes 2 XX No 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ 4 Nursing Home 5 XX esidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 \square Yes 28d. Describe how injury occurred Certificate: XX_{Natural} injury 5 Pending 2 No Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Xertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 3 only one) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 23601 December 8, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10710 Charter Drive Edward Lee, M.D. Suite G020 Columbia, Maryland

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ Willie A. Bagley O) Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A OTE 20 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X**□ M 2 □ F 220-74-4237 **Director** 2/14/59 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State death with the Maryland Director N/ABaltimore 1 🙀 Yes 2 ☐ No MD 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 320 S. Hilton St. 21229 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ڄ Maryland 21215-0036 within 72 hours after African Amer 1 ☐ Yes 2 ☐ No Specify: Yes Give 3 Widowed 4 Divorced Completed Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Loyala College <u>Floor Tech</u> 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) marked Cottie O'Neal Jesse Luther Bagley and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a Sheryl Simon/Dom. Partner 320 S. Hilton St., Balt., MD 21229 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

Zion Cem. Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/16/10 Balt.,MD Mt. 22. Name and Address of Facility Hari P. 21. Signature of Furniral Service Licensee Close F.Svs, PA 21206-5105 Belair Rd, Balt MD_ 23a. Part 1. Énter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final . 01 Physician/ a otherosclas disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death cate has been signed by the a page 2 should be detached a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division/of Vital Records, 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? performed 1 🗌 Yes 2 🗌 No this certificate 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After work' 1 Natural 5 Pending 2 🗌 No death. 1 Yes Accident Investigation or Attend after death Director; / completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 000 24 hours a Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 9b. Signature and title of certifi Name and address of person who completed cause of death (Item 23a) (Type, Print) (3 14 32. Registrar's Si State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 29d per dr., g910 12/13/2010dhb

Reg. No.

Reg. No. 1 - For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Kathleen S. Beaty DECEMBER /Medical 4b. City, 4c. County of Death 4a Facility Name (If not institution, give street and number) Jown, or Location of Death **Examiner** I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/12/1934 If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Hours 1 □ M 2 🔀 F Days Marylan 76 214-30-2663 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaning must be notified at once. 1 □Yes 2 No Harford Belcamp Directo Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 1123 Belcamp Garth 21017 Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify:White 1 □Yes 2 XNo þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Help Housekeeper 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Philip Kurth Loretta Wagner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1502 Alexis Dr. Joppa, MD 21085 Lois Runk / Daughter 20b. Place of Disposition (Name of cemetery, crematory, or other place)
R.A. Ferris & Co. 20c. Location - City or Town, State West Chester, Pennsylvania Date 20a Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 12/6/2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Tarring-Cargo Funeral Home, P.A. 333 S. Parke St., Aberdeen, MD S. Parké St., Aberdeen, MD 21001 anle 23a. Part 1. Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a anone Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of): Due to (or as Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 □Yes 2 □No nis certificate has been signed by the director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 3 Probably 4 ☐ Unknown 2 - No 1 Tes Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Unursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation safter death.

I Director: Af in by the fur 1 ☐Yes 2 ☐No 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier $\leftarrow 12/06/2010$ Men 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M16 W

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Date Month 9 3. Time of Death 2010 Physician/ 6:37 Рм Μ. Booker Dec Eleanore Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Timonium Stella Maris Hospice 8. Date of Birth (Month, Pay, Year) 1917 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 □ M 2 🕱 F Months Hours Mary Land 93 219-16-8137 Director Usual Residence of Decede or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State death with the Maryland Director 1 Yes 2 No Baltimore Towson Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21204 USA 3 Theo Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event". Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Frank Agnes Trcinski Markiewicz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Towson, Maryland 21204 Robert R. Booker/Son Theo Lane DECEMBER 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holv Rosary Cemetery | 12/13/10 Baltimore, Maryland 22. Name and Address of Facility Ruck Towson Funeral Tome, Inc. Signature of Funeral Service Licensee 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ CEREBROVASCULAR ACCIDENT disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events g physician and is the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical ELEANORE BOOKER Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) B examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 2 X No 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No injury 1 X Natural 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 MD 21093 2300 DULANEY VALLEY RD. TIMONIUM. JUNECIA WHITE, 31. Date filed (Month, Day, Year) 32. Registuar's Sign State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 Physician/ Рм William John Clark, Sr 7:55 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** na Balto <u>516 Sheridan</u> <u>Avenue</u> 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Min Yrs **Director** 220-64-5581 Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Baltimore MD na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral S A U 21214 516 Sheridan Avenue and Mental Hygiene.
is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify. Specify 3 Widowed 4 ☐ Divorced Completed Year or Dates na 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 2th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Maynor Arthur Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto, MD 21215 Wilern Avenue Nina Clark-Daughter injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o 1 Burial 2 XCremation 3 Removal from State 12-13-10 Balto, MD Greenmount 4 ☐ Donation 5 ☐ Other (Specify) March East F/H 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Md 21202 Avenue Balto, 1101 E. North 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or a lence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Dire to (or as a consequence of). Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the bunal-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) isigned by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed is certificate has been si director, page 2 should i Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: nours after death.

neral Director: After this or
filled in by the funeral dire 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: ✓ Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 0000516 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

ON

21

31. Date filed (Month, Day, Year)

2122

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ M 5:15 P. DECEMBER ANDREW CUNEO Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1102 GREEN ACRE ROAD TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Ye /4/1937 1 🛛 M 2 □ F Vear Director MARYLAND 216-34-0945 Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be notified at 10a. State 10b. County Director 1 Yes 2 XNo BALTIMORE TOWSON MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 USA 1102 GREEN ACRE ROAD and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc. 1X Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Completed by Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify Specify: WHITE 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 6+ YEARS Elementary/Seconday (0-12) PHYSICIST ARMY nd Mental Hygier marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ ANDREW A. CUNEO, SR. MARIE GROB and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a JOHN CUNEO/BROTHER 19 GREENBRIAR DR SUMMIT 07901 other Baltimore, item 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State MOST HOLY REDEEMER 4 Donation 5 Other (Specify) 12/20/2010 BALTIMORE. MD CEMETERS ame and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MO0217 BLVD. TOWSON. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death tonetton Immediate Cause (Final Physician My o cand disease or condition resulting in death) Lmin Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) ng physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Physician: The law requires that the death certificate be P.O. Box 68760 attending p IF FEMALE use a yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year 5 Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed' 2 14 No this certificate 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Other: 2 1 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of e Hospital or Attending Pi 24 hours after death. e Funeral Director: After the Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 52016 2016 amara 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Eant 33 NO 200

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

DEC 13 2010

State Registrar 30. Name and addre

31. Date filed (Month, Day,

Year)

3 1

DHMH 17 Rev 1/2001

of death (Item 23a) Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Bellona Lane #216 Towson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Day Yea Physician/ 2010 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner 01 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** (Month, Day, I an 24 Country) Utah Months Days Min 1 □ M 2 😿 F Hours Jan Yrs 577-48-3698 1936 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at **Funeral Director** 1 🗆 Yes 2 🙀 No MD Anne Arundel Riva 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? þ 23a 5 Dogwood Road 21140 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status an "natural", or iter Medical Examiner Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: If Yes, Give white 3 ☐ Widowed 4 🎇 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry filed within 72 al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) other traumatic event, the 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental H ၉ Dorothy Jensen Carl Raymond Peterson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 279 Quane Avenue Spring Hill, FL 34609 19a. Informant's Name/Relationship (Type, Print) S Carol Bussian/sister 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 1 Burial 2 Cremation 3 Removal from State injury 4 ☐ Donation 5 🗓 Other (Specify) in state State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Funeral Service Licensee Ronald S W 23a. Part 1. Poter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or beart failure. List only one cause on each line. erval Betweer Onset and Death Parciatio Immediate Cause (Final Physician/ Mus disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** 2PSis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): unk attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events 16141 death certificate be executed 14 Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death detached 9 Unknown q Unknown P.0. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed Yes 2 death? 1 Tyes 2 No Yes 26. Place of Death (Check only one) of Vital 25. Was case referred to medical Be examiner? ၉ 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 \(\sum \) Yes 2 \(\sum \) No the Hospital or Attending (Month, Day, Year) injury 1 Natural 5 Pending Division death. Investigation ☐ Accident completed filled in by the within 24 hours after deal To the Funeral Director: 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: Lethe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific ρ on who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers 2001 MC 31. Date filed (Month, Day, Year) State 2010 3

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 04:50 P M December Mary Lou Cole Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner None Baltimore 4300 Keswick Road 8. Date of Birth (Month, Day, Year) September 7, Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. Rhode Island 1946 64 Director 037-30-5245 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10a. State 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 □ No Baltimore Maryland None 10f. Zip Code ö 10e. Street and Number 10g. Citizen of What Country? items 23a or ner must be r Funeral United States 21210 4300 Keswick Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces? Black, White, etc. ö þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Legislative Director Politics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be file f Health and Mental H item 27 is marked o ၉ Helen Guilmette John Brennan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4300 Keswick Road, Baltimore, Maryland 21210 Stephen Luby Cole/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important; If ite
any injury or ot
once, cemetery, crematory or other place) 1 XI Burial 2 ☐ Cremation 3 ☐ Removal from State December Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bestgate Memorial Park 201Ô Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. Will E Bou M00672 411 Annapolis Road, Odenton, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph sician/ Renal Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Bilateral Ureteral Obstruction 4 Months Sequentially list conditions, Examiner Due to lor as a consequence of cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed 57 Months Endometrial Carcinoma Cause (Disease or iiniury trans and that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 X No Month Day Year Pregnant at time of death 1 Yes 2 2 Unknown by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed δ should be 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 nerformed? death? this certificate 1 Yes 2 No ☐Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 💢 No 1 Tyes မူ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after death.
I Director: After to in by the funeral Certificate: work? 1 ☐ Yes 2 ☐ No injury X Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Hospital 24 hours within 2 To the I

State

DHMH 17 Rev 7/2009

Registrar

only one)

29b. Signature and title of certifier

Drive, Suite 2200, 9103 Franklin Square 32. Registrar's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) December 6, 2010

29c. License number

D16801

William P. McGuire,

Baltimore, Maryland 21237

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, ITEM#30perFH, G910, 12/13/2010 WS State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 05:30 M Month 2010 08 Physician/ ulius 4c. County of Death Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner na Baltimore Bon Secours Hospital Birthplace (State or Foreign Country)
 MD 8. Date of Birth If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday, Social Security Numbe MD Min. Days **Funeral** 939 1 🛛 M 2 🗆 F 70 218-36-4588 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. County 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 1 🛶 Yes 2 🗌 No Director Baltimore MD na 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21223 USA Completed by Funeral Fayette Street 1217 W. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces 1 Yes 2 No If Yes, Give Year or Dates. Black 1 Never Married 2 Married Specify: 1 ☐ Yes 2 X No Specify: Maryland 21215-0036 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry unk 15. Decedent's Education grade completed) (Specify only highest College (1-4 or 5+) Elementary/Seconday (0-12) na Barber 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Evelyn A. Carter ၉ Julius A. Day 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Balto, MD 21216 2407 Baker Street Nicole Day-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Balto, MD 12-10-10 Greenmount East F/H March 22. Name and Address of Facility . Signature of Funeful Service Licensee Bull Millen 21202 Balto, North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy Year 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown Completed by 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 Mo 24a. Was an autopsy performe Yes 2 X N 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner: 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 2 No မ 28d. Describe how injury occurred 28b. Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: work? 5 Pending 2 🗌 No 1 Natural 2 Accider Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be Suicide
Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner stated. 29a Certifier (Check 29d. Date signed (Month, Day, Year) within 2 To the F only one) 29c. License number Signature and tille 2010 D41734 address of person who completed cause of death (Item 23a) (Type, Print) Balto. MD 21201 Jackson University of MD School of Medicine 110 Paca St. Marie C. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ HARRY FREDERICK DAWSON 12:43 A M December 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BAHIMORE HOSDITA HARBOR 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland Hours Min. (Month, Day, 123/193) 1 XM 2 - F 214-26-2102 Director 79 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Fath tifere 72 is marked other than "natural", or items 23a or 28a-f sho tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho itury or orlier traumatic event, the Medical Examiner must be notified at jury or orlier traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director MD Baltimore Arbutus 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3513 Clover Avenue 21227 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc 1 Never Married 2 Married __ Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Self Employed 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည unknown Mary Frederick Dawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2863 Hollins Ferry Road Baltimore, Maryland 21230 Gail Wagner daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 ☐ Burial 2 XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bavview Crematory Inc. Dec. 9, 2010 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 237 Fast Patapsco Avenue. Baltimore. Marvland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 2 YEARS shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician, HEART FAILURE CONGESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury the Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-trans signed by the attending physician and be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 ☐ No 3 ☐ Probably 4 ☒ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 \(\triangle \) Nursing Home 5 \(\triangle \) Residence 6 \(\triangle \) Other (Specify) Hospital 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No ျှ After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending death. Accident Investigation 24 hours after death Funeral Director; filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \ Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ретопрос Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗖 within 2. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NikitA PozdeYEY RES 0001 2010 December 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NikitA PozdeYEV South HANOVER STEEF BALTIMORE MD 3001

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

13

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 5, 2010 0625 AM Physician ecembe /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. 8. Date of Birth Main Month, Day, If Under Months Birthplace (State or Foreign Country) Age (In yrs. last birthday) curity Number 6. Sex **Funeral** Days 1 M 2 TF Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No TIMONE Directo 10f. Zin Code 10g, Citizen of What Country? 10e. Street and Number 1,6 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by 3 PWidowed 4 □ Divorced Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date City or Town, State 2 □Cremation 3 □Removal from State 1 Burial 745 4 ☐ Donation 5 Other (Specify) 21. Signature of Funeral Service License 22 Name and Address of Facility 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MINS Physician disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available Be Certification; To

/Medical Examiner To the Hospitel or Attending Physician: The law requires thet the death certificate be executed es the burial-transit Division of Vital Records, P.O. Box 68760 the attending physicien ō deteched ል efter death.

Director: After this certification by the funeral director, within 24 hours eff To the Funeral DI completely filled in

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours elter deeth with the Marylan Department of Heelth and Mentel Hygiene. Important: If Itsm 27 is marked other then "natural", or Items 23e or 28a-f show any Injury or other traumatic svent, the Medical Examines mante be notified at

Baltimore, Maryland 21215-0036

											autopsy performed?	prior to completion of cause of death? 1 □ Yes 2 □ No		
25	. Was case referred	to medical			26. Place of Death (Check only one)									
	examiner? 1 Yes 2 No			Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient			OOA Other: 4 Nursing Hor			Home	me 5 Residence 6 Other (Specify)			
27	Manner of Death 1 Natural 5 2 Accident	i ☐ Pending investigation		la. Date of Injury (Month, Day Yea	z) 28b. Time of Injury	М	28c.	Injury at Work? 1 Yes		28d.	Describe how inju	ry occurred		
		6 Could not be determined									28f. Location (Street and Number or Rural Route Number, City or Town, State)			

156 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

ful Kay MO	D0053373	December 5, 2010
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Paul Kan mo	2018
31. Date filed (Month, Day, Year) DEC 13 2010 Review H. Again	New S	

Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 7 2010 Physician/ Wanda Marie Davey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Regional Laurel HOSPITA Laure If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** July 29, Year) 1 🗆 M 2 🛛 F Months Davs Hours Min. Tennessee 410-16-8612 88 **Director** Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 X Yes 2 No MD Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 20708 9262 Cherry Lane #41 U.S.A mit. Page 1 and 2 should be filed within 72 hours after death vartment of Health and Mental Hygiene. portant: I fitem 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner m. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: Completed 3 ☑ Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) United States Elementary/Seconday (0-12) College (1-4 or 5+) Government Contracting Officer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 은 Nicholas McDaniel permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Lily Hicks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys Greer / Per. Rep. Lane #43, Laurel, Maryland 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arundel Crematory Dec 10, 10 Odenton, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Donaldson Funeral Home, 313 Talbott Ave. Laurel, M00773 Maryland 20707-4389 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Retween Immediate Cause (Firlal Physician/ Acute Respiratory Medical resulting in death) Due to (or as a consequence of): Examiner Se Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Dehydration Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death g | I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform this certificate has page 2 death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? 1 🗌 Yes 2 X No ပ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c, Injury at . Manner of Death Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: After injury 1 X Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and file of certifie 29d. Date signed (Month, Day, Year) D70093 201 Laurel Regional Hospital 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), 7300 Van Dysen 31. Date filed (Month, Day, Y 32. Registrar's State 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Angelina Dharan December 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Greater Baltimore Medical Center Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year) Country 1 □ M 2XX Months 73 Director 477-56-5711 Feb. Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes XXNo Kings Park New York Suffolk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11754 11 Glen Rd. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XXNo
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 🙀 No Specify: Specify: Indian 3 Widowed 4 Divorced Year or Dates. Permit. Page 1 and 2 should be filed within 72 hour begartment of Health and Mental Hygiene.

Moortant: If item 27 is marked other than "natur ally injury or other traumatic event, the Medical Jonce. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care 5+ Medical Doctor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Kamalam Solomon D.R. Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 319 Fox Lair Dr., Reisterstown, MD 21136 Silas Victor / Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Alimeter, censory or charges at ory 12/13/10 Manchester, MD and Chapel 1 🗆 Burial 🗶 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Censes 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approxim e Interval Between Onset and Death Physician/ Schemic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Early Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

24 hours after death.

15 Hoursal Director: After this certificate has been signed by the attending physician and eter filled in by the funeral director, page 2 should be deteched for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hypertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Cynthia Smallo NO 10051347 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St Baltimore MO 21204 Registrar's Signature State Registrar

Registrar

DHMH 17 Rev 7/2009

State

hoch Raven

Baltimore MD 21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANA H FRANCIO 31. Date filed (Month, Day, Year)

DEC 13 2010

5601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 23a per dr., g910 12/13/2010dhb

Certificate of Death

Reg. No. 1 - State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** 01:44 AM Marie Grace Anna MOV 13 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Agnes

5. Social Security Number HOSPITA MD Ballinogue Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 06-23-1912 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2/CXF Months 214-01-6799 MD 98 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 X No Director Arbutus MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21227 Funeral 1306 Poplar Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes **X**[X]No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 📆 🖠o Specify If Yes, Give Year or Dates: ģ Specify: ¥XWidowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If Item 27 is marked other than ury or other traumatic event, Iha. Many or other event, Iha. Many or othe College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cecelia Katherine Herbert Anthony Maczis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1306 Poplar Avenue, Arbutus, Maryland 21227 Margaret Bury - daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of himportant: If ite any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park | 11-19-2010| Elkridge, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service MMP., Inc, 7250 Wash. Blvd., Elkridge, MD 21075 Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Urinary Tract Infection Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Gram Negative Bacteremia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to for as a consequence of: Exami or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 1 □ Yes 2 **☑** No funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2₩No 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical соmpletely (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Nerry Nov 13 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) · Agnes 900 Caton Ave, Ballinove, MD, 21229 HOSPITA

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Robert Pau1 Gardner Dec 2:45 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Bel Air Upper Chesapeake Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, 1**X** M 2 □ F Months Days Hours Min. Country) Marvland 1963 Director Feb. 214-90-0300 Usual Residence of Decedent 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Harford Be1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2810 Henley Drive United States 21015 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married Married þ If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: "natural", 3 Widowed 4 Divorced Completed White the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 7 f Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Construction Worker Baltimore County 12 Years other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joanne Marie Isabella Vaughn Paul Gardner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2810 Henley Drive Bel Air, Maryland Mrs. Donna Gardner (Wife) Page 1 and 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ō 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Sacred Ht. of Jesus Cem. 12/11/2010 Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Buda-Ruck Funeral Home of Dundalk, Dundalk, Maryland 7922 Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final INFARCTION ₽nysician/ MYOCAUDIAL disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** - DBA-CC D BUSE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of HTPERTWILL attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day by the 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 □ Probably 4 □ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 10 Hospital Other: 2 🗌 No 2 ER/Outpatient 3 DOA Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: s after death. 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Faminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 2 Medical Chaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signa nd title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 254781 12 08,200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 520 Upper Chosapea Ke Dr. Suite 306 Beldic MO 21014 32. Registrar Signature rails State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Barbara Physician/ 1510 201 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner MD Randallstow P Baltimore orthwest HOSPI Ta If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 24, 1951 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday **Funeral** 1 🗆 M 2 🕱 F Hours Maryland **Director** 219-58-2698 59 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗌 Yes 2 🔀 No MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 42 Garrison Ridge Court 21117 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. ğ 1 Never Married 2 X Married ☐ Yes 2 🛛 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Specify. 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Payrol1 Supervisor J. Schoeneman Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ James Johnson Mary Jane Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Garrison Ridge Court Owings Mills, MD 21117 Lawrence Stokely Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Ser 12/13/10 Hampastead, MD . Signature of Juneral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Men ELINE FUNERAL HOME Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final lat Embolism Ph sician/ Medical resulting in death) Due to (or as a consequence of) Examiner embolism monary Sequentially list conditions. Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying arrhythm the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) been signed by the sahould be detached 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given n Part I Did tobacco use contribute to the cause of death? þ 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performe Yes 2 No 1 Yes 2 No After this certificate Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of injury (Month, Day, Year) i 2 | 06 | i 0 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 | Matural 5 Pending tell in Bathroom 1 ☐ Yes 2 Z No 3:55M Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 2 40115 m 121452 C+ determined HOME Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 12-09-2010 FL0437372 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 Old Court Road Rundall Stown, MD 21133 Inattassery MP 31. Date filed (Month, Day, Year)
DEC 1 3 2010 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 4, 2010 Physician/ 10:42 P M David Randall Hyatt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Odenton 292 St. Michaels Circle 8. Date of Birth (Month, Day, July 2, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 1 🛛 M 2 🗆 F Months 1947 ATabama 63 212-54-5927 Director Usual Residence of Decedent 10d. Inside City Limits nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland rartment of Health and Mental Hygiene.

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shor injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2X No Maryland Anne Arundel 0denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21113 292 St. Michaels Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Force 1 ☐ Yes 2 🕅 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sheet Metal Works Office Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Sara Cambell David Hyatt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 292 St. Michaels Circle, Odenton, Maryland 21113 Stasia Nicol Gilbert/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place)
West Arundel
Crematory December 7, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Odenton, Maryland 21. Signature of Funeral Service Licensee Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 Will Elaones M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician a Metastatic Gastric Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Anemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No **Director:** After this certificated in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2 X No မူ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending Investigation Accident
Suicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🖔 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Weltz, D.O.,

3

Martin D. Welt
31. Date filed (Month, Day, Year)

D23743

7525 Greenway Center Drive, Suite 205, Greenbelt, MD 20770

December 6, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. The Phy G910 12/13/10 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Physician/ Hauber Catherine 301 Catherine Medical 4a. Facility Name (if not institution, give street and nu 4b. City, Town, or Location of Death 4c. County of Death Examiner HOS 9. Birthplace (State or Foreign If Under 24 Hrs. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 - M 2 - F Months Hours Min Apr 22, 1930 214-26-0684 80 Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f shor must be notified at Director 1 Yes 2 X No Parkville Baltimroe MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21234 1801 Wentworth Road items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 0 1 Never Married 2 Married by Latherine Hauber Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: black "natural", 3 Widowed 4 Divorced Completed Year or Dates nnk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry Health and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk Be unk filed 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) ပ be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5601 Loch Raven Blvd Baltimore, MD 21239 Good Samaritan Hospital Department of Health Important: If item 27 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ☑ Other (Specify) in state Funeral Servic Ron State Anatomy Board 655 W. Baltimore Street MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph sician/ ecer Medical resulting in death) Due to (as a consequence of: Examiner ecur Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated experts.) Examine Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the as yes, outcome of pregnancy
Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Day Pregnant at time of death 5 Other (specify) the a Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1) island 3 Probably 4 Unknown Records, 1 Yes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I page 2 s autopsy death?
1 Yes 2 No certificate Yes 2 No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) director, Be examiner? Hospital 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA မ 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and tiple of certifie 29c. License numbe Date signed (Month, Day, Year) Name and address of person who co pleted cause of death (Item 23a) (Type, Print) Loch Fuvan 5601 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:22 2010 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington 144 Plantation Drive Hagerstown 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min 1 🕅 M 2 🗆 F Months Oct 10, Year) 916 Maryland **Director** 217-10-9790 94 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No Washington Hagerstown ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21740 USA 144 Plantation Drive er than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2X Married 1 Yes If Yes, Give Maryland 21215-0036 e filed within 72 hours after tal Hygiene. ed other than "natural", o 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) repairman refridgeration Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file h and Mental F 7 is marked of ပ Byron Elsworth Harley Grace Remsburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Harley/spouse 144 Plantation Drive Hagerstown, MD 1 and 2 s of Health item 27 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Signature of Euneral Service Licenser 22. Name and Address of Fa State Anatomy Board 655 W. Baltimore Street Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that the death certificate be executed for use as the burial-transit N that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) Month Day Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 death? 1 Yes 2 🗌 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 St Residence 6 Other (Specify) ၉ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Medical Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11-29-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Muhammad Khalid Waseem 1126 Opal Court Hagerstown, MD 21740

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Department of Maryland	tificate of Death	Reg.	21111 39122								
	Physicia		1. Decedent's Name (First, Middle, Last) Elizabeth Hofmann		2. Date of Death Month December	3. Time of Death 2:35 P M								
	Medic Examin		4a. Facility Name (if not institution, give street and number) Gilchrist	4b. City, Town, or Location of Death		4c. County of Death Baltimore								
	Funeral Director		5. Social Security Number 219-44-8310	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Birthplace (State or Foreign								
	/laryland 8a-f show tified at	Funeral Director	Usual Residence of Decedent 10a. State	cation		10d. Inside City Limits 1 ☐ Yes 2 🛛 No								
:	vith the N 23a or 2 st be no	ral Di	10e. Street and Number 13 Nantucket Garth	10f. Zip Code 21131	10g.	Citizen of What Country?								
036	filled within 72 hours after death with the Maryland Hygiene. Hygiene. At Jethygiene. At other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 XMarried 1 Yes 2 XNo	Vas Decedent of Hispanic Origin? (Spec f Yes, specify Cuban, Mexican, Puerto R Yes 2 X No Specify:	ify Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White								
Maryland 21215-0036	hin 72 hour ne. than "natur e Medical	Completed	(Specify only highest grade completed) (Give I Elementary/Seconday (0-12) College (1-4 or 5+)	lent's Usual Occupation kind of work done during most of working O NOT use retired)	g	b. Kind of Business Industry								
and 2		To Be C	17. Father's Name (First, Middle, Last) Glen Myers	ce Manager 18. Mother's Name Betty Ry	(First, Middle, Maio									
	ge 1 and 2 should be file It of Health and Mental I I fitem 27 is marked o or other traumatic eve		19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	ng Address (Street and Number or Rural	Route Number, City	y or Town, State, Zip Code) aryland 21131								
<u>≒</u>	Page 1 and ment of Heal ant: If item ? ury or other			s Cemetery 12-15	5–2010 _Н չ	c. Location - City or Town, State /des, Maryland								
Balt	permit. Page Department Important: If any injury or once.				ck Towson wson, Mar	Funeral Home, Inc. yland 21204								
- P	h sician/		23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition											
الميب	Medical Examiner	L	resulting in death) Due to or as a consequence of): Sequentially list conditions, b.											
,	icate be executed to physician and sthe burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):											
٠	cate be cate by physicial the bur	edical	d			r								
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after darkth. within 24 hours after darkth. within 24 hours after darkth. completed filled in by the funeral director, page 2 should be detached for use as the	Physician/M		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year								
ls, P.O.	uires that the signed by aid be detac	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		co use contribute to the cause of death?								
Records,	The law requate has bee page 2 short	Completed			24a. Was an autopsy performed 1 Yes 2									
Vitai	ysıcıan: s certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatier	26. Place of Death (Check of at 3 □ DOA Other: 4 □ Nursing Hon	,	e 6 D Other (Specify) Hospital								
Division of Vital	eath. or: After thi the funeral	Certificate: 7	27. Manner of Death 1	28c. Injury at work? M 1 □ Yes 2 □ No	8d. Describe how in	njury occurred								
DIVIS	tal or Att rs after d al Direct ed in by t		4 Homicide determined 28e. Place of Injury - At home, farm, streen building, etc. (Specify)	eet, factory, office 2	t and Number or Rural Route Number, tate)									
	the Hospi nin 24 hou the Funer npleted fill	Medical	29a. Certifier (Check (Check only one) 1	tigation, In my opinion, death occurred at t death occurred at the time, date and place	the time, date and pl e, and due to the cau	lace, and due to the cause(s) and manner stated. use(s) and manner as stated.								
	0. Viti		29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)								
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, F Lawn Patel 6701 N Chartes St &	rint)	more M	0 21204								
ı	Stat Registra		31. Date filed (Month, Day, Year) OFC 13 2010 32. Registrar's Signature A. Aavest											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month December 11 2010 Physician/ 10:30AM HENSLER DA Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner JOHNS HOPKINS BAYVIBN MEDIKAL CENTER BALTMORE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 F Days Jumpy 108, 1925 Mary Land Hours Min. 85 218-14-6147 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notional once. 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 Yes 2 No Baltimore Dundalk Md. 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number by Funeral 21222 U.S.A. 1820 Walnut Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Damasiewicz James Stacharowski 19a. Informant's Name/Relationship (Type, PriMusband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1820 Walnut Avenue Baltimore, Maryland21222 Melvin Hensler, Sr. **Baltimore**, 20b. Place of Disposition (Name of December 20c. Location - City or Town, State 20a. Method of Disposition St. Stanislaus Cem. 15, 2010 Baltimore, Maryland 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, P.A 21. Signature of Funeral Service Licen Roha Avenue Baltimore. 21222 1201 Dundalk 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HYPOVOLEMIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner AORTA Sequentially list conditions, if any, reading to in mediate cause. Enter Underlying Cause (Disease or linjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit ANEUR AORTIC that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Year Dav Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 🔀 26. Place of Death (Check only one) 25. Was case referred to medical æ examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗆 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 December 11,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Reeve

Grin

31. Date filed (Month

4940 Eastern Ave Baltimore MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, perFH, G910, 12/13/2010, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December Physician/ 2010 11:09 AM Eugene S. Kelley Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Regional Hospita dure rince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 14, 1951 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) Funeral 1 **№** м 2 🗆 ғ Months Days Hours Min. Yrs. Director 59 102-42-1659 Aug. Usual Residence of Decedent 28a-f shov 10b. County 10a. State with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 √ Yes 2 □ No Prince George's MD Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14009 Justin Way, Unit D 20707 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. University of Elementary/Seconday (0-12) Callege (1-4 or 5+) 12th Computer Programmer Maryland Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eugene S. Kelley Mary Ellen White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Marie Kelley/Daughte 111 West Clinton Street, Apt. 1, Ithaca, NY 14850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🗆 Burial 2 ី Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/10/2010 Odenton, MD West Arundel Crem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707 M01103 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septic Physician/ Shock disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner neumonid Sequentially list conditions, Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 2 Anoxic Encephalopathy 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Muscular Dystrophy 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No Failure Respiratory 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗶 No Other: 2 1 Inpatient 2 ER/Cutpatient 3 DCA After this 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred X Natural 5 Pending injury Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature nd title of certifier 29d. Date signed (Month, Day, Year) D69430 12/04 2010

Registrar
DHMH 17 Rev 7/2009

State

7300

31. Date filed (Month, Day, DEC 13

Van

Laurel

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dusen

Road

32. Registrar's

Nega Ali Goji

Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2010 Elizabeth A. Krizek Dec. 10 11:38 A^M Medical 4a. Facility Name (if not Institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Silver Spring Renaissance Gardens If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
Feb. 27, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 M 2XX Maryland 93 1917 Director 218-05-7022 Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Jimporatant if fine 27 is marked other than "natural", or items 23e -- any injury or other traumatic event, the Marie any injury or other traumatic event. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2XXVo Silver Spring MD Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 20904 3160 Gracefield Rd. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 ☐ Yes XX No If Yes, Give Year or Dates. 1 ☐ Yes XX No Specify: Specify: White XX Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Svec Anna James Sou1 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 27 S. Lake Way; Reisterstown, MD 21136 Alice Bafford / Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other p Druid Ridge ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/14/1d Pikesville, MD 4 Donation Synther (SpecifyEntombment emetery 22. Name and Address of FacilitEckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mi**11**s, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Dementia Physician. Alzheimer,s Medical resulting in death) Due to (or as a consequence of) Examiner CHF Sequentially list conditions, if any, leading to immediate cause. Enter or danying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Cause (Disease or linjury SIP CVA that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician the dor use as the burian Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death neral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier All2633 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gracefield Rd. Silver Spring, MD 20904 Julaine Harding, CNP 3110 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day ser 30,2010 renc oveni 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death 4b. City.

Physician /Medical Examiner

State Registra

Funeral

Director 72 hours after death with the Maryland 28a-f show 23a or or items 'natural" filed within 7 Hygiene.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the buriat-tran P.O. Box 68760, signed by the a of Vital Records, cate has page 2 s within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag

Division

ommon Date of Birth (Month, Day, Year) Age (In yrs. last birthday)

83
Yrs. Birthplace (State or Foreign Country) 1 M 2 □ F Min. Usual Residence of Decedent Months Days Hours 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 √res 2 No Director mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No ģ Specify: 3 Widowed 4 Divorced Û Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other the any Injury or other traumatic event, If e. Once. 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Be ပ arke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility OSEPH L. RUSS Funeral Service License 21. Signature W. North 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dior disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) □Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗖 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mille D4768] 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

Registrar

Kaymona

Date-filed (Month,

Milli

2835

Smilt

32. Registrar's Signature

203

Baltonere

Ave

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deat 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🙀 F Feb 23, 1920 Hours Maryland Director 216-80-6615 90 Yrs Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director must be notified 1 Tes 2 K No MD Baltimore Reisterstown ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 307 Academy Avenue 21136 U.S.A. items within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Examiner Armed Forces Black, White, etc. ō by 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" 3 X Widowed 4 Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clvde Green Roxie Creighton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana F. LeDonne Daughter 307 Academy Avenue Reisterstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parkwood Cemetery 12/11/10 Parkville, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No ŕ Day Month Year Pregnant at time of death the should be detached Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? this certificate 2 🗆 No 1 🗌 Yes Yes 2 No the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: 2 NO 1 🗌 Yes Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Manger of Death 28a. Date of injury 28b. Time of s after death. I Director: After t Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 - Pending 1 Natural 1 Tyes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 6 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 20 IC Name and address of person who een pleted cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death FC Embe Physician/ 8 2010 HYMAN Medical a Facility Name (if not institution, give street and number) County of Death

Saltinor 4b. City, Town or Location of Death Examiner owson sh Medical DSE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 ¼ M 2 □ F Months Davs Hours Min. 027784 1918 92 NY 130-03-9799 Director Usual Residence of Decedent arment of Health and Mental Hyglene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State **Funeral Director** 1 Yes 2 TrNo TIMONIUM BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12246 ROUNDWOOD ROAD, #409 21093 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced WHITE Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12College (1-4 or 5+) BUSINESS OWNER FIREPLACE EOUIPMENT Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file.
Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic ဂ္ LEVY STELLA COHEN ISAAC 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEVERLY LEVY/DAUGHTER 12246 ROUNDWOOD ROAD, #409, TIMONIUM, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State WORKMEN CIRCLE CEM 12/10/2010 BALTIMORE, MD Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death . Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No Inpatient 2 ER/Outpatient 3 DOA ဂ္ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: or Attending 5 Pending X Natural 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ce eted cause of death (Item 23a) (Type, Print) Name and address of person who comp 31. Date filed (Month Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2070 Stephen Lehner 1 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Center Hospita & ware osedale 9. Birthplace (State or Foreign 6. Sex 1 M 2 F 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Min. Feb. 1920 Months Maryland 215-18-3722 90 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified and once. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 😡 Yes 2 🗆 No Berlin Md. Worcester 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral U.S.A. 755 Ocean Parkway 21811 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give Black, White, etc. ğ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 XWidowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Western Electric Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Zapf John Lehner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Ocean Parkway Berlin, Maryland 21811 Donald Lehner / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition December 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 13, 2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ACCOTOWS K1 Funeral Home, PA 21. Signature of Funeral Service License 1201 Dundalk Avenue Baltimore, Md.21222 brilow 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiopu/monary arres Priysician/ disease or condition Medical resulting in death) Due to (or as a onsequence of): Examiner Neum onia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner ang Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death 9 Unknown signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Obstructive Disease Pulmonar 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of mokina 24a. Was an Secondary has autopsy death? 1 Yes 2 No ours after death.

eral Director: After this certificate hilled in by the funeral director, page Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 Natural 5 Pending Investigation ☐ Accident☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral I

completed filled Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Husegul Gozu, MD 9000 Fnank 31. Date filed (Nonth, Day, Year) State Registrar

			Please 7	Type or Prir								•				
	State of Maryland / Department of Health and Men 1 - State Registrar Certificate of Death										ental Hygiene Reg. No. 0 0 39 30					
		1. Decedent's Name (First, Middle, Last)							2. Date of Death Month							
Physicia /Medic		RAYMOND	ANTHO		[CHA]	LSKI				12	9	20/	3.	41 PM		
Examin		4a. Facility Name (If not in			. 101				r Location of Death		40	County of Do	eath NOSC			
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1. W 2 F 7. Age (In yrs. last birthday) 1. W 2 F 7. Age (In yrs. last birthday) 1. W 2 F 7. Age (In yrs. last birthday) 1. W 2 F 8. If Under 1 Year 1. Months Days Hours Min.								8. Date of B	irth ay, Year)	9. [tate or Foreign			
Director		212 03 773 Usual Residence of Dece	9	2411 201	90	Yrs				03/09	/19.	20 M <i>E</i>	RYLA	ND		
r 28a-f show	5	10a. State 10b. County 10c. City, Town or Location												de City Limits Yes 2X No		
the M	recto	10e. Street and Number				<u>-</u> -	10f. Zip (Code			10g. Ci	tizen of What				
death with the Maryland	ralD	1407 MT A					21237			US	SA					
irs after ir, or ite	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 3 🔀 Widowed 4 ☐ □		12. Was Decedent Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates:			 Was Decede If Yes, speci 1 ☐ Yes 2 		lispanic Origin? (S an, Mexican, Puerti Specify:	pecify Yes or N o Rican, etc.)	0-	14. Race - American Indian, Black, White, etc. Specify: WHITE				
"natural"	eted	15. D (Specify on	ا Decedent's Edu ly highest grad	ucation de completed)	-	(G	ecedent's Usual	k done i	durina most of wor	king	16b. K	and of Busine	ss/Industry			
within iene. than "	Completed	Elementary/Secondary	(0-12)	College (1-4or 5	5+)	lif	e. DO NOT use NGSHOF	e retired	d) -		STI	EAMSHI	P TR	ADE		
be filed that Hyging of the second of the se	BeC	17. Father's Name (First,				L			18. Mother's Nan	•			_			
d 2 should be filed w th and Mental Hygie 7 is marked other t traumatic event, In	၉	STANLEY 19a. Informant's Name/R		HALSKI		10b M	ailing Address	(Street	LOTTI			KOWSK]				
permit. Pages 1 and 2 s Department of Health an Important: If item 27 is . any Injury or other trau		DONNA M. K	KUHNER			25	08 FOX	R	OAD FAL		MD		7			
Pages nent of nt: # it		1 XBurial 2 ☐ Crei	mation 3 🗆				sposition (Nam crematory or oti VN CEM		CRY 12/1			TIMOR				
ermit. epartri nporta ny Inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERA										INERA	L HOME			
<u> </u>		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												ximate		
Physician /Medical Examiner	iner	shock, or heart failu Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immedia cause (Disease or injury Cause (Disease or injury	(a. Due to (or as	a consequ	uence of):						8	Onset	al Between and Death		
ficate be executed physician and s the burial-transit	edical Examiner	Due to (gr as a consequence of):									indrom					
Attending Physician: The law requires that the death certificate be readsh. ector: After this certificate has been signed by the attending physicia by the funeral director, page 2 should be detached for use as the burn	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)									23d. Date of delivery Month Day Year					
w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions continuously to death out not resulting in the underlying value given in Part I.									tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown					
sician: The law re certificate has bee irector, page 2 sho	Completed	05 Was 222 (2021)			-					per 1 □ Yes	opsy formed? 2 N	prior deat	to completio	dings available on of cause of		
lysicial is certi directo	To Be	25. Was case referred to examiner? 1 ☐ Yes 2 ☑ No	-	Hospital:	ent 2 🗆	ER/Outpa	atient 3 DO	A Oth	26. Place of Dea ner: 4 Nursing H	ith <i>(Check onl)</i> Iome 5 ☐ Re		6 ☐ Other (\$	Specify)			
ding Phys h. After this funeral dir	on:	27. Manner of Death	☐ Pending	28a. Date of Inju (Month, Da		28b. Tim Inju	ry	Bc. Inju	rk?	28d. Describe	e how inju	ury occurred	, ,,			
of or Attendia after death. Director: A d in by the fu	Certification:	2 Accident investigation M 1 Lives 2 LiNo									and Number or Rural Route Number, te)					
To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	Medical (29a. Certifier (Check only one)	Certifying Ph Medical Exam	ysiclan: To the best niner: On the basis of and manner st	of examina	wledge, o	leath occurred or investigation,	at the ti	ime, date and place opinion, death occ	e, and due to the urred at the tim	ne cause e, date ai	(s) and manne nd place, and	r as stated. due to the ca	ause(s)		
To the Comp	ž	29b. Signature and title o	of certifier	2000					se number		29d. D	Date signed (Month, Day, Year)				
1.1		30. Name and address of	f nerson who	completed cause of	death (Iten	n 23a) /Tu	ne Print)	05	0000		12	-9-	201	0		
1211		MARYAM	SAEE	A PLY-	3 9	U00	Frank	lih	59 Mar	2 dr	loge	dale 1	11	21237		
Sta Registr	_	31. Date filed (Month, Da	3 2010	32. Regist	rar's Signa	A d	wed		square					•		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#12,19a,perFH,G910,12/15/2010,WS

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAGGE 1 Year Medical 4a. Facility Name (if not institution, give street and n Examiner BACTIMO LOCH RAVEN COMMUNIT CENTER N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral X**□ M 2 □ F Country) Director 240-17-8229 52 129/58 NC Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant If item 27 is marked other than "natural", or items 23a or 28a-f sho ral", or items 23a or 28a-f shore Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore MD 1 ¥ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 404 Mt. Holley St. 21230 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Bace - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 Speckfrican 1 Yes 2 No Specify: 3 Divorced 4 Divorced Year or Dates.1979-81 Amer. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Building Elementary/Seconday (0-12) Construction 10 traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Thomas Maggette Edwinnetta Boone 19a Informant's Name/Relationship (Type, Print) ELIIa Hendricks Christine Sham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $507\ WestMain\ St, Woodland,\ NC$ /Sister Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of 1 🗶 Burial 2 □ Cremation 3 □ Removal from State 12/15/10 Conway,NC Creeksville CH. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hari P. . Signature of Funeral Service License 22. Name and Address of Facility Hari P. Close F. Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner WE POLMONA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed for use as the burial-trans and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy Yes 2 No Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 XNo ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number **D246** 48 29d. Date signed (Month, Day, Year) COCH RAVEN BLUD BACTIM 00 filed (Month, Day, Year) State 3 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dec. Meninger Marie Thelma 2010 12:30 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Riverview Nursing Home Baltimore Co. Essex Social Security Number 8. Date of Birth (Month, Day, Year)
Nov. 17,1919 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 M 2 X 91 Director 212-16-0208 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matter and one. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2X No Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7500 Bayfront Road Apt. B United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Laboratory Worker Medical 7 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Emma Rogers John H. T. Hutchinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 614 Tidewater Lane Baltimore, Maryland 21220 Laura Landon (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Baltimore, Maryland 12/13/2010 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 21. Signature of F / al Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 21222 Wise 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a cons **Examiner** Sequentially list conditions, Examine if any leading to in models cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of resulting in death) Last the attending physician Physician/Medical emic Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 4 Pregnant 9 Unknown Pregnant at time of death page 2 should be detached g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s after death.

I Director: After this certificate has autopsy performed? Yes 2 No 2 🗌 No 1 Yes Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) title of certi 29b. Signature a 29c. License number D0055171 and address of person who completed cause of death (Item 23a) (Type, Print) 3023 menue MD 21224 JOL Eastern astran

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year

13 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Physician/ 7·24 M 12 10 2010 Riley Merson Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George Laurel Regional Hospital 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Aug 30, Days Hours Min. 1 🕅 M 2 🗆 F Maryland 66 1944 Director 217-42-2546 Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f shov must be notified at 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No Prince George Laurel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20707 U.S.A. 8311 Holly Street items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 9 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Waste Management Train Operator Be 18. Mother's Name (First, Middle, Maiden Surname) filed 17. Father's Name (First, Middle, Last) ge 1 and 2 should be file it of Health and Mental | If item 27 is marked o ပ Nellie Buschman Joseph Riley Merson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8311 Holly Street, Laurel, Maryland 20707 Shirley M. Merson /spouse or other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 🗌 Burial 2 🔀 Cremation 3 🗌 Removal from State Arundel Crematory Dec 13, 10 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Mar 21. Signature of Funeral Service Lense Maryland 20707-4389 -W M00773 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hupertensi Due to (orde a consequence of): executed that initiated events resulting in death) Last -tran and as the burial attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ Unknown Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been signated bage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director; After this certificate I 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Be examiner? Hospital: Other: 2 M No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: work?
1 Yes 2 No 1 🗹 Natural injury 5 Pending ☐ Accider☐ Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 1 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 46952 impleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who Sukhjit Singh Sidhu, M.D. 7300 Van Dusen Road, Laurel, Maryland 20707

State Registrar 10-09357 Brian Molnar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

rian Moinar		- For State		tificate of		141011	a, rrygiono	Reg. No	2010	19104	
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Do Month	eath Dav	Year	3. Time of Death 0128 hrs					
/ledical Exami		Brian David Molnar 4a. Facility Name (if not institution, give street and number	1	T _A	b. City, Town,	or Location o	Decemb f Death	er 6, 2	01201115		
		Harbor Hospital Center	,		Baltimore]	Baltimore		
Funeral Director			ge (In yrs. Ia	st birthday) Yrs.	If Under 1 Ye Months Da	ear If Unde			hplace (State or intry)Maryland		
	ŀ	Usual Residence of Decedent							,		
w any		10a. State 10b. County		Town or Location						10d. Inside City Limits 1 Yes 2 No	
Aaryland 28a-f show 1 at once.	Ř	Maryland Anne Arundel 10e. Street and Number	Gren	Burnie	10f. Zip Code			10g. Ci	tizen of What Coun		
ith the Maryland 23a or 28a-f she	Director	106 Water Fountain Way #30	3		21060			Uni	ted State	c	
with the ms 23s be not		11. Marital Status 12. Was Deceder	t Ever in U.S		Decedent of I	lispanic Orig	in? (Specify Yes or Puerto Rican, etc.)		14. Race - America		
r death	Funeral	1 X Never Married 2 Married 1 Yes 2	X No		_		Tuerto Ricari, etc.)			* * ~	
rs after ural", miner	ā	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade co	mpleted)		Yes 2 X N		kind of work done	16b.	Specify: Wh Kind of Business/li	ite	
72 hou	eted	Elementary/Secondary (0-12) College (1-4 or		during mo	st of working li	fe. DO NOT	use retired)				
Vithin 7. ene.	Completed	11		Survey	or	Land	's Name (First, Middle		urveying	Company	
21215-0036 wild be filed within 7 Mental Hygiene. marked nither than c event, the Medica	_	17. Father's Name (First, Middle, Last) Robert N. Molnar					s Name (First, Middio ne Elaine				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked auther than "natural", ar items 23a or 28a-f sh injury or other traumatic event, the Medical Examiner must be notified at once	10 B	19a. Informant's Name/Relationship (Type, Print)		19b. Mailing	Address (Str		ber or Rural Route N			Zip Code)	
MD td 2 shoulth and m 27 is aumati		Roger Molnar / Brother	Look B	821 R			ltimore, N		1and 2122 Location - City or		
Baltimore, permit. Pages I ar Department of Hee Impartant: If ite		20a. Method of Disposition 1	tate c	rematory or oth	er place)		Dec. 10,		•		
ti. Pag rtment rtant: y or of		4 Donation 5 Other Specify: 21. Sanat as of Funetal Service Licensee	Met	tro Cre			2010			e, Maryland	
Ba permi Depa Inpu		Transit C. K.		Ki 42	rkley-H l Crain	Ruddic Hwy.	k Funeral , S.E., G	Hom Len	e, P.A. Burnie, M	D 21061	
Physician		23a. Part I. Enter the disease, or complications that cause failure. List only one cause on each line.	d the death.	Do not enter th	e mode of dyin	g, such as c	ardiac or respiratory	arrest, sl	hock, or heart	Approximate Interval Between Onset and	
xaminer	ı	Immediate Cause (Final disease or condition resulting in death) a. Complication To Complication			troint	estina	1 Carcino	ma		Death	
		Sequentially list conditions, b.	sequence or).							
	ner	if any, leading to immediate Due to (or as a con	sequence of	·):						ļ	
ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last	sequence of	·):							
(68760, certificate be executed anding physician and ise as the burial - transit	Medical	M. UNPENDED AMENDED 2	3a,pt	.11,27	per me	g912	2-25-11 v				
3760, ificate be g physicist the burn	_/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcomes the second s	me of pregr		al death	3 Ectopic	pregnancy	2	3d. Date of delivery Month	ay Year	
Box 6876 e death certificat the attending ph ed for use as the	iciai	past 12 months?	at time of dea		ner (Specify)						
	Physician/	Part II. Other significant conditions contributing to dea	ith but not re	esulting in the u	nderlying caus	e given in Pa	art I. 23e. Di	d tobacc	o use contribute to	the cause of death?	
res that the signed by I be detacle		Hypertensive Cardiovas		_				Yes 2	No 3 Prob	ably 4 🗸 Unknown	
rds, requir been s	Completed by			-			24a. W	as an topsy		topsy findings available completion of cause of	
of Vital Records, og Physician: The law requir Helew this certificate has been s uneral director, page 2 should l	ФШО					·	1 ✓ Ye	rformed	? death? No 1 ✓ Ye	s 2 No	
tal Recision: The certificate	BeC	25. Was case referred to medical examiner? Hospital: 4 Inner				1011	(Check only one)	7			
on of Vital ending Physician: eath. nr: After this certifi	ျ	1 Yes 2 No 1 Inpat 27. Manner of Death 28a. Date of Ir		ER/Outpatient 28b. Time of Ir		njury at Work	Nursing Home 5		njury occurred	:	
on of anding P ath. T. After he funera	tion:	1 X Natural 5 Pending (Month, Day	(Year)			Yes 2					
·= = 3 # ~	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of	Injury - At ho	ome, farm, stree	t, factory, offic	e building, el		n (Street	and Number or Ru	ral Route Number, City	
	Cert	4 Homicide determined (Specify) 29a. Certifier A Certifier Physician To the best of									
To the Hos within 24 h To the Fun	Medical	(Check only one) 2 Medical Examiner: On the basis of ex	amination a	ge, death occur nd/or investigat	red at the time, ion, in my opin	date and pla ion, death oc	ace, and due to the c ccurred at the time, d	ause(s) a ate and p	and manner as state place, and due to th	e cause(s)	
To 1 With To 1	Med	and manner stated			nse number			d. Date signed (Mo			
		0-2			0.0	C.M.E.		December 6, 2010			
rperd		30. Name and address of person who completed cause of			Penn Stra	et Raltim	ore, MD 21201	•			
	tota	Donna M. Vincenti, MD Assistant Med 31. Date filed (Month, Day, Year)	rar's Signaw			ei, Dailiiii					
S Regis	tate	31. Date filed (Month, Day real)		. Lyan	G-H-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ РМ Nager 09 2010 Т. George December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bayview Medical Center <u>Baltimore City</u> 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** (Month, Day, Days Switzerland 1 X M 2 D F 1917 93 **Director** 2-36-4615 Usual Residence of Decedent or 28a-f show be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland Director 1 🔀 Yes 2 🗆 No N/A Baltimore City Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 21218 USA 4403 Bedford Place 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 X No If Yes, Give Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mee College (1-4 or 5+) Elementary/Seconday (0-12) Medicine Medical Doctor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 <u>Emma B. Reinhart</u> <u>Felix R. Nager</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4403 Bedford Place Baltimore, Md. 21218 Thomas R. Nager/ Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u> Hilltop Service Co.</u> 12-15-10 Towson, Md. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 2120 21. Signature of Fug al Sice Linese 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Physician/ 12 hours disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner month Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit pertension that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fail 2 No 3 Probably 4 Unknown 1 \square Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director. After this certificate has t completed filled in by the funeral director, page 2 s performed 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. з 🗌 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lochka 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G910 12/13/10 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ O'BRIEN BRENDAN K. DECEMBER 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE NOTTINGHAM 9530 OAKBRANCE WAY If Under 1 Year If Under 24 Hrs. 8 Date of Righ Social Security Number 7, Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 3/14/1967 1 X M 2 □ F Months Days MARYLAND Director 217-62-3706 43 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland traumatic event, the Medical Examiner must be notified at Director MD BALTIMORE NOTTINGHAM 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Funeral items 23a 9530 OAKBRANCH WAY 21236 USA Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 XMarried Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) AUTOMOTIVE TECHNICIAN CHEVRON 12TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JAMES O'BRIEN MARIE DOELGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARNIEN O'BRIEN/WIFE 9530 OAKBRANCH WAY NOTTINGHAM, MD injury or other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12/PF 2010 Department of Important: If it any injury or o METRO CREMATORY, INC. 12/13/2010 CATONSVILLE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. Signature of Funeral Service Licensee MO1139 8521 LOCH RAVEN BLVD. TOWSON, MD 231 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Esophareal Immediate Cause (Final ancer Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) months Examiner Sequentially list conditions, if any, is a light to him estate cause. Enter Underlying Cause (Disease or linjury Examiner Take to for an a positivous of ed by the attending physician and detached for use as the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician; The law requires that the death certificate be Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Character at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 🔼 No 1 Tes 2 🔀 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 X No 1 Tyes 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 X Natural 5 Pending M Accident Investigation within 24 hours after death To the Funeral Director. 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) KHALID MIAN 2010 Dec. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21244 Miank Khalid, 7141 Security Blvd. Woodlawm. MD 31. Date filed (Month, Day, Year) State **DEC 13** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Oxendine December Physician/ Lilly Virginia 2010 10:51 PM Medical 4a. Facility Name (if not institution, give street and numbe 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Unit 203 Tiree Court Harford Abingdon 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Yea
April 20, 9. Birthplace (State or Foreign **Funeral** 227-24-3326 Months Davs Hours Min Virginia 1926 Director 84 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits irector Abingdon MD Harford 1 Yes 2X No Ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Unit 203 311 Tiree Court United States 21009 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2√X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3XXWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 8 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mary Christian Samuel Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
29 Lake Drive Bel Air, Maryland 21014 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Tommie Lark Martin (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Gardens of Faith Cem. 12/8/2010 Baltimore, Maryland 4 Denetion 5 Other (Specify) 21. Sonature of uneral Sa Duda-Ruck Funeral Home of Dundalk, 0 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line, Immediate Cause (Final Physician/ F AR ONGESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner MEN Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine ANTHRITIS KHEUM ATOIN Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 2 1 No certificate 1 Yes Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred ✓ Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) ECEMBER WW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND 21030 OLD EMMORTON 31. Date filed (Month, Day, Year) 62. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3:15 pm Month Physician/ EL -12 ABetu Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA Humare escuck Nursing Home 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1 🗆 M 2 🔽 Months Hours 246-12-9674 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Funeral Director 1 Yes 2 No MO Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1400 E. Madeson St 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Blac 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Seam Sewing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Flossie Chavis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah C. Hudges Bactemore MD wharten 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Dundalk, MD Dec 14,200 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Rmale as Ina
270 FRED L 21. Signature of Funeral Service Licensee real service weld Corcurer MD 21229 270 Hilton 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VemenTIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examiner Due to (or as a nonsequence of) cause (Disease or linjury as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No ò Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by INSUFFICIENC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Anemia page 2 s autopsy certificate has performed Yes 2 No 1 Tes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursin Home 5 ☐ Residence 6 ☐ Other S ecity 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as talted | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as talted | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as talted | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place are the cause(s) and manner as talted | Certifying Nurse Practice | Certifying Nurse | Certifying Nurse | Certifying Nurse | Certifying Nurse | Cer 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 3510 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HILLOWY DN H-D. 390 1 NOVTh CHO CHANIES Mary 31. Date filed (Month, Day, Year) State 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day V. Piper Mary Dec. 2010 6 6:17 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Center Timonium Baltimore Co. Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. (Month, Day, Year) Country Director Virginia 100 West 218-30-6705 Aug Usual Residence of Decedent or 28a-f show 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location or other traumatic event, the Medical Examiner must be notified at Director 1 Tes 2XXNo MD Baltimore Essex 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 21221 104 North Stuart Street United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 1 ☐ Yes 2 No Specify. Specify: "natural", 3√X Widowed 4 □ Divorced Year or Dates. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marshall P. Grove Annie V. Lancaster Health and N tem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Doris L. Lowe (Daughter) 104 North Stuart Street Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 🗆 Cremation 3 🗔 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Edge Hill Cemetery 12/10/2010 Charles Town, WV ^{22. Name and Address of Facility}
Duda-Ruck Funeral Home of Dundalk,
7922 Wise Ave. Dundalk, Maryland Funeral Service Licenses Signatur 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or help failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph sician/ END STAGE RENAL DISEASE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performed? Yes 2 X No 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 2 X No HOSPICE ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛣 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending after death. Director: Aft 1 Tyes 2 \square No Accident Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and #tle 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar JACKIE JONES

31. Date filed (Month, Day, Year)

CRNP

)ECEMBER

MD 21093

TIMONIUM.

2300 DULANEY VALLEY RD.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Sue Ramey Betty December 2010 9:20 A Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Co. 1723 Melbourne Road Dunda1k Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) eb. 24,1937 1 □ M 2**X** F Months Days Hours Min **Director** 73 Kentucky 406-46-1177 Feb. Usual Residence of Decedent 28a-f shov and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Dundalk Baltimore 1 Yes 2 XNo MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 United States 1₹23 Melbourne Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ð 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: Specify Completed 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Eva Beatrice Byrd Lawrence Lee Lovely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1723 Melbourne Road Dundalk, Maryland 21222 Ruel B. Ramey (Husband) item 27 i other tra 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1.
Department of Important; If it any injury or or once. 1 Burial 2XXCremation 3 Removal from State cemetery, crematory or other place; Hilltop Service Corp. 12/7/2010 Towson, Maryland 4 Donation 5 Other (Specify) Buda-Rucks Fufferal Home of Dundalk, Inc. Marvland 21222 rvice License 21. Signature of Fu al. 7922 Wise Ave. Dundalk, Maryland disease, or copplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Pa 1. En er th shock, or hear failure. List only one cause on each line nterval Between Immediate Cause (Final Onset and Death Physician/ REBROVASCULAR MAG disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner YEARS ATHERUSCIERUSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of): Exami SYEARS ettending physician and for use as the burial-transit TEL Hospital or Attending Physician: The law requires that the death certificate be executed DIABETES that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy performed' Yes 2 W 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending work?
1 Yes 2 No Accident Investigation 24 hours after deatl Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. пріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 **To the I** only one) 3 🗌 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12 2010 7-3340 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Deepak Seth, M.D.

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Dundalk, Maryland

207 Wise Ave.

32. Registrar's Signature

0-09461 Vayne Elliott Red		Please Typ th St	oe or Print i ate of Maryla	and / Dep	ndelible li artment of ertificate of	f Health	and I	All Copie Mental H	es Are L ygiene			0	39 4	
Physicia Medical Examin	n/	Registrar 1. Decedent's Name (First, Midd	_{e,Last)} Wayne	Elliot					2. Date of D Month Decemb	per 9, 2			Time of Death 0502 hrs	
		4a. Facility Name (if not institution Calvert Memorial Hos		umber)		4b. City, Tow Prince F		cation of Death			. County of I Calvert	Death		
Funeral		Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1	Year	If Under 24Hrs	_	Birth(MM/	DD/YYYYDD'	9. Birthpla	ace (State or	
Director		218-40-1828	№ м 2 F	.66	Yrs		Days	Hours Min.	Dec.	30,1		Countr	y) MD	
any	H	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Locat	ion							d. Inside City Limits	
* .	٥	MD Bal	timore				nda1	.k					Yes 2 X No	
ne Maryi or 28a-	Director	10e. Street and Number	1 D 1			10f. Zip Co		1222			Country?			
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Intt. If item 27 is marked other than "natural", or items 23s or 28s-f sho re other traumatic event, the Medical Examiner must be notified at once.	틸	2809 Southbr	12. Was Dec	cedent Ever in U			of Hispar	nic Origin? (Sp			14. Race - A	American	Indian, Black,	
r death or iten	Funeral	1 Never Married 2XXM	1 X Yes	2 No				lexican, Puerto	Rican, etc.)		White, e	etc.		
urs afte tural",	<u>اھ</u>	3 Widowed 4 Div 15. Decedent's Education (Spe	orced If Yes, Give Yes or Dates: cify only highest gra			nt's Usual Occ	cupation	(Give kind of v		16b. I	Specify: Kind of Busir	W ness/Indu	hite stry	
6 172 hou		Elementary/Secondary (0-12)	College (1-4 or 5+)			g life. D0	O NOT use reti	red)		ryland minist			
15-0036 filed within 72 Hygiene. d other than '	Completed	12 Years 17. Father's Name (First, Middle,	For	eman	18.1	Mother's Name	(First, Middl			Iall				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	æ	Wendell Burne	tt Reddis	h, Sr.					Ann Frazier					
MD 21 d 2 should lith and Me m 27 is ma	욘	19a. Informant's Name/Relations Mrs. Donna E.		Wife)				nd Number or F ook Roa						
Baltimore, MD 21215: permit. Pages I and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked of injury or other traumatic event, the	ŀ	20a. Method of Disposition		20b.	Place of Dispos crematory or ot	ition (Name o			Date		Location - C			
Baltimore, bernit. Pages I an Department of Hea Important: If iten injury or other tri		1 Burial 2 X Cremation 4 Donation 5 Other S		rom State Hi	11top S		Coı	rp. 12	/13/20	10	Towson	, Ma	ryland	
Balti Permit. Departit Import		21. Signature of Funeral Service	Licensee		Du	dame and Add da-Ruc	dress of K Fu	inera1	Home o	f Du	ndalk,	Inc	222	
Physician	+	23a. Part I. Enter the disease, or failure. List only one cause	complications that o	caused the deat	h. Do not enter t	922 W1 he mode of d	SE A ying, suc	ve. Di	r respiratory	arrest, sho	ock, or heart	A	pproximate Interval Between Onset and	
/Medical -xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Hyper		Arther	oscler	otio	Cardi	ovascu	lar 1	Diseas		Death	
yd*		Sequentially list conditions,	Due to (or as a	a consequence	of):									
	ie.	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	a consequence	of):									
ed sit	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence	of):									
executed ian and al - transit	ᆍᄔ	X UNPENDED	d AMENDED	23a,p	t.II,27	per m	e g9	13 3-3-	-11 vt					
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the		outcome of pre	-		• 🗀	F		23	d. Date of de		Vens	
x 68° h certifi tending use as	ician	past 12 months?	4 Pregr	birth nant at ti <mark>me of</mark> d	looth -	tal death her <i>(Specify)</i>		Ectopic pregna	ancy	Î	Month	Day	Year	
. Bo.	hys	Part II. Other significant condit	9 Unkn		resulting in the	inderlying ca	use give	n in Part I	23e. Di	d tobacco	use contribu	te to the	cause of death?	
res that the signed by the detact	ձ	Chronic Alco	-		_								4 V Unknown	
rds,	letec								24a. W.	as an topsy			y findings available detion of cause of	
ital Records. ician: The law requii	Completed									rformed? s 2 N	o dea	ith? Yes	2 No	
Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be rs after death. The law requires that the death certificate has been signed by the attending physic led in by the funeral director, page 2 should be detached for use as the burner.	æ	25. Was case referred to medica examiner?	11 21 1	Innatient 2	✓ ER/Outpatient		Oth	Death (Check	only one) ig Home 5	Reside	ence 6	Other:		
of Vi	와	1 ✓ Yes 2 No 27. Manner of Death		e of Injury h, Day,Year)	28b. Time of I			at Work?			ury occurred			
Sion (ttendin death. etor: A	The state of the s									(0)				
Divis Divis Is after al Dire	TE LE		ld not be rmined (Specify)		home, farm, stre	et, factory, of	tice build	ding, etc.		n (Street a n, State)	ind Number	or Rurai F	Route Number, City	
Division of a Division of within 24 hours after death. To the Waperal Director: After to completely filled in by the funeral	2 E	29a. Certifier 1 Certifying P	hysician: To the be	st of my knowle	dge, death occu	rred at the tim	ne, date	and place, and	due to the ca	ause(s) an	d manner as	stated.		
To the within To the comple	Medical	one) 2 Medical Exa 29b. Signature and title of certific	miner: On the basis and manner:		and/or investiga		inion, de		at the time, da		ace, and due Date signed			
	2	255. Signature and this or certific	// -	/	MI	i	C.M.I				ember 10			
at perch	+	30. Name and address of person												
		Russell Alexander MD		Medical Exa		Penn Str	eet, Ba	altimore, M	D 21201					
Sta Registi		31. Date filed (Month, Day, Year)	10 6	egistrar's Signa	A CLA	21								

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 4a. Facility Name (If not institution, give street and number) 0406 AM A,2010 seconber /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) Jan 27, 1995 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2XX Days 080-84-3484 15 Yrs Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No XX Director MD Howard Laurel 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 9462 Canterbury Riding 20723 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [XXo] If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Wever Married 2 Married Specify: Dominican 1 X Yes 2 □ No \$ Specify: Latino 3 Widowed 4 Divorced Republic Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Grade Student student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pedro Rosario Teresa Tejeda ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Rosario mother 9462 Canterbury Riding Laurel, Maryland 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Col. Prim. Bap. Churdh 12/8/10 4 Donation 5 Other (Specify) Burtonsville, MD 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee / M00770 313 Talbott Avenue Laurel, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Diliary disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3

Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 2 No Unknown the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion or cause of death? 24a. Was an autopsy performed has 2 No 2 No 1 TYes certificate or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA ည 28a. Date of Injury 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 Yes 2 🗌 No 2 Accident after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760, the Hospital

> State Registrar

29a. Certifier

one)

(check only

JUST IN

31. Date filed (Month, Day, Year)

DEC 13 2010

29b. Signature and title of certifier

- MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID

32. Registrar's Signature

LOCKMAN

Medical

DHMH 17 Rev 1/2001

24 hours a Funeral L

Barker

1 XXertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

RES-000

29d. Date signed (Month, Day, Year)

December 4, 2010

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:01 December 2010 Medical lity Name (if not institution, wiversity of 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Baltimore niversitu Social Security Numb If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Days Min Decnt 1. Day 1952 212-60-5691 Maryland Director Usual Residence of Decedent or 28a-f shov 10a State 10b. Count 10c. City. Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at **Funeral Director** Maryland N/A Baltimore 1 A Yes 2 □ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1503 William Street items 23a 21230 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc Yes 2 X No ò 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Mental Hygiene. arked other than Elementary/Seconday (0-12) College (1-4 or 5+) Harbor Hospital Admitting Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked 2 George Frank Seltzer Willy Pauline Horn and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erik J. Seltzer (Son) f Health 1612 Parkman Avenue, Baltimore, Maryland other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If ite 1 Burial 2 X Cremation 3 Removal from State injury or Dec. 13, 2010 Baltimore, Maryland Bayview Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 130 East Fort Avenue, Baltimore, Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ oticem Medical resulting in death) Examiner Sequentially list conditions, it any leading to immediate Physician/Medical Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 2 9 Unknow 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Completed by hypertension, coronary 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 1 Yes Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospita 2 **1**No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Accident Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifie: 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29c. License number ed cause of death (Item 23a) (Type, Print)

Registrar

State

32. Registra

Greene Street,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Dante Sweeney 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2 Date of Death 3. Time of Death Physician/ Month **Medical Examiner** 2343 hrs December 7, 2010 Dante X. Sweeney 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore Funera 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Months Hours Director 215-17-8143 1 X M MD 12-12-1987 2 F Country) Yrs 22 Usual Residence of Decedent 10d. Inside City Limits any 10a. State 10c. City, Town or Location 10b. County Baltimore MD 1 X Yes 2 No na permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f she injury or other traumatic event, the Medical Examiner must be notified at once Director 10f Zip Code 10e. Street and Number 10g. Citizen of What Country? 21214 6409 Laurelton Avenue USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 2X No If Yes, Give Year 1 Yes 2 X No specify: Black 3 Widowed 4 Divorced Specify: \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry na Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Itimore, MD 21215-0036 9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles M. Sweeney, Sherry D. Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry D. Ward-Mother 6409 Laurelton Avenue Balto, MD 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State King Memorial Pk 12-14-10 Randallstown, Donation 5 Other Specify: 21. Signature of funeral Service Licensee March East F/H 22. Name and Address of Facility Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and trans Physician/Medical attending physician for use as the burial -UNPENDED **AMENDED** Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 ned by the atte 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed s been s 24b. Were autopsy findings available prior to completion of cause of has , page 2 s performed? death? certificate ✓ Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other DOA this 1 🗸 Yes 28a. Date of Injury 28c. Injury at Work? After 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: Dec 7, 2010 Subject shot 1 Natural 2316 hrs Pending 1 Yes 2 ✔ No Director: d in by the f Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 ___ Suicide 6 ___ Could not be or Town, State) 5300 Loch Raven Road Apt C, Baltimore, MD filled determined (Specify) Multi-Family Apt. 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) **OOME** O.C.M.E. December 8, 2010 30. Name and address of person who completed called of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, NFC 13 32. Registra s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month C Physician/ 0051M 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Unde If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs last birthday) **Funeral** -930 1 □ M 2 🛛 F Months Min Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be norified one. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 1 Yes 2 □ No more 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. PO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ s Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informar aughter 20a. Method of Disposition
1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Dațe 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility
JOSeph L. KUS
2772 W. North Home Ave. r complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Enter de disease, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ severe sepsi Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of: executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Day Year 5 Other (specify) Pregnant at time of death ed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe 2 No Yes 2 1 🗀 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2. No Other: 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at I Director: After the din by the funeral 28d. Describe how injury occurred 1. Natural 5 Pending work? 2 🗌 No M 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours a Medical Prifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dec

State Registrar

P.O.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM#26perpHYS, G910.12713/2010, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.- Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day noff Month Physician/ Hiam Dec 2010 7:10 p. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Aldworth Road Dunda1k Baltimore 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 😿 M 2 □ F Months Days Hours Min. (Month, Day, Year, Maryland Director May 16, 1936 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 XNo Dunda1k Maryland Baltimore 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 21222 737 Aldworth Road United States permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Force Black, White, etc. Completed by 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Maintenance 6 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jack N. Schoff Ruth Langhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 737 Aldworth Road (Wife) Patricia L. Schoff Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 💢 Cremation 3 🗔 Removal from State ☐ Donation 5 ☐ Other (Specify) 12/13/2010 Towson, Maryland Hillton Service Corp. 21. Signa are of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 21222 7922 Wise Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC FURDENDOIR INE Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 4 Pregnant a been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PULMONALY OBSTRUCTIVE 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has le 2 s autopsy performed? death? within 24 hours after deam.

To the Funeral Director: After this certificate homeleted filled in by the funeral director, page CORONARY ARTERY 1 🗌 Yes 2 🗎 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Tother (Specify) 2 100 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ZDAKIS MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PL. BALTIMORE MD 21207 PAUL 32. Registrar's Signature State 3 ack Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Mopth di Barbara Sheets 425AM Martha Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death Bel Air Healthand Rehabilitation Cente 6 0 \mathcal{C} If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Oct. I1, 1920 Hours 1 □ M 2 🕱 F Months Mary Tand 90 Director 217-16-6732 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes XX No Dundalk Baltimore MD 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? ō "natural", or items 23a o edical Examiner must be Funeral Apt. 813 Center Place 21222 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 😿 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates. event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Housewife permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If item 27 is marked other i any injury or other traumatic event, th 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frances Haag George Bayer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Pandalk Marvland 21222 19a. Informant's Name/Relationship (Type, Print) 1785 Brookview Road Dundalk, Maryland Janet Stevens (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Hilltop Service Corp. 12/8/2010 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as correspiratory arrest, shock, or heart failure. List only one cause on enter the death. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Medical a consequence of) Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Exami the burial-transi Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 cate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death Other significant onditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: ဂ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Aesidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury Natural work? 1 ☐ Yes 2 ☐ No Investigation Accident 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
Certifying Norse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State Registrar

only one 29b. Signature and the

31. Date filed (Month, Day, Year,

1308 18USI

32. Registrar's Signature

dress of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Scarcella Dec 2010 6 11:30 A^M David Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore City 6424 East Pratt Street Apt. 411 Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Month, Day, Ye **Funeral** Months Days Hours Min XXM 2 F 216-34-3680 West **Director** 1938 Virginia March Usual Residence of Decedent show or 28a-f shown notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Baltimore MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ıral", or items 23a o Examiner must be Funeral 6424 East Pratt Street Apt. 411 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Was Decedo... Armed Forces? 1 ⊠ Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify. Completed 3 Widowed 4 X Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Owner Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Mary Frances Scarcella Vincent Scarcella James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernadette Drohan (sister) PMB 6929 N. Hayden Rd. Scottsdale, Az. 85250 0a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) 12/08/201d Towson, Maryland 1top Service Corp. 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk Signat of Funeral Service Licensee Inc. 7922 Wise Ave. Dundalk, MD. 23a. Part 1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nediate Cause (Final ease or condition Physician/ Muocordia arction Medical resulting in death) Due to (or as a consequence of), Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): s been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has autopsy perform After this certificate Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) director, Be Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation after death Director; Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) the within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 182/3/3057

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Baltimore, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher Bach, M.D. 4940 Eastern Blvd.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician/ 20:00M 11 llen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview Medical Baltimose N/A Johns Hopkins 8. Date of Birth (Month, Day, Year) Sept. 6, 1941 If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 6. Sex Social Security Number Funeral Min Davs 1 M 2 12 F Months Hours Maryland Director 216-36-5779 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Funeral Director must be notified Dunda1k 1 ☐ Yes 2 X No 28a-f MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe ò 23a United States 21222 7833 Lockwood Road permit. Page 1 and 2 should be filed within 72 hours after death I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. ğ 1 Never Married 2 X Married Yes 2 XNo Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 7 Years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Ellen Dee William Schmuck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) North East, Maryland 41 Woodview Lane Mr. Bryan K. Shockey (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date K Burial 2 Cremation 3 Removal from State 12/13/2010 Baltimore, Maryland Woodlawn Cemetery Donation 5 Other (Specify) 21. Signati of Funeral Service Lice 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. once. 21222 7922 Wise Ave. <u>Dundalk</u>, Maryland ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ abs una disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner u u Sequentially list conditions, Due to (or as a consequen of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending the circum and Due to (or as a consequence of) resulting in death) Last ending physician a Be Completed by Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Year Pregnant at time of death 1 Yes 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 **N**No မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year, 28c. Injury at filled in by the funeral Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: work? 1 WNatural 5 Pending Division 2 🗆 No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier ±305 Whom ecember Johns Hopkins Bayview Medical Ctr. 30. Name and address of person who completed cause of death (Item-23a) (Type, Print) Baltimore, Maryland 21224 4940 Eastern Ave. Day, Year) 31. Date filed (Month) 32. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** James Stokesberry November 2010 4:40 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel 9 Rene Drive Brooklyn 8. Date of Birth (Month, Day, Year) FEb 28, 1944 5. Social Security Numberunk 6. Sex if Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 ₹ M 2 □ F Pennsylvania Director 66 Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ∏ No Brooklyn Anne Arundel MD filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21225 USA or items 23a 9 Rene Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: þ Specify: white 3 √ Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 10 0 truck driver construction marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence WEaver Estelle Marie Pettigrew ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Bill Stokesberry/brother 3041 Bow Creek Blvd Virginia Beach, VA 23452 27 other Department of Heal Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5▼Other (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wa 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, at heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** theresclerous disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner abetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner to (or as a consequence of) requires that the death certificate be executed and the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? for Month Day Year 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, sign be c Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an S autopsy , page or Attending Physician: The perform certificate SX 1 □Yes 2 No Was case referred to medical examiner?
1 □ Yes 2 No funeral director Be 25. 26. Place of Death (Check only one) Hospital: Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No hours after death uneral Director: / the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ determined 4 Homicide filled in within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b Signature and title of certifier 29c. License number nd address of person who ed cause of death (Item 23a) (Type, Print) KATHLERE CL HOHUN hillebulle State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Amend Item 25 per me,g910,12/17/2010dhb 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ December 06:25 M 2010 TRA RAY SUSSMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital of Baltimore City Baltimore N/A Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 🗆 F 1272371932 Director 062-26-1199 77 NY Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b, County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD BALTIMORE REISTERSTOWN 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21136 11976 LONG LAKE DRIVE USA 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married ģ 1 ☐ Yes 2 ☐ No Specify: Specify: Completed 3 Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) ENGINEERING 4 ELECTRICAL ENGINEER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any inJury or other traumatic ev ABE SUSSMAN MINNIE HEITZER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNETTE SUSSMAN/WIFE 11976 LONG LAKE DRIVE, REISTERSTOWN, MD 21136 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) MARYLAND VETERANS 12/16/2010 OWINGS MILLS, MD 21. Signature of Furneral Service Licel 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. o not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death HYPOXIA Fh sician/ 1 day disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Aspiration 1 day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) DICAL EXAMINER Exami Cause (Disease or impury that initiated events IN APPROVEUS Due to (or as a consequence of) resulting in death) Last CERTIFICAT attending physician a for use as the burial-Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Squamous Cell Oropharyngeal 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 2 No prior to completion of cause of death? Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Sivision of 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES - 600 occember 6,2010 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABADILLA OF BALTIMORE KATRINIA MO SINSAI HOSPITAL

State Registrar 31. Date filed (Month, Day, Year)

20

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER. 2010 12:10 AM RONALD SHADOFF Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON GILCHRIST HOSPICE CARE Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday 8. Date of Birth **Funeral** Hours 047067 1954 **Director** 016-46-7190 56 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No HOWARD WOODSTOCK MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10731 FOLKESTONE WAY 21163 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black. White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Completed Specify: 3 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) OWNER FINANCIAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ FISHMAN SHADOFF JANICE HAROLD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOAN SHADOFF/WIFE 10731 FOLKESTONE WAY, WOODSTOCK, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12/10/2010 4 Donation 5 Other (Specify) BETH EL MEMORIAL PK RANDALLSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Licersee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of): Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicial completed filled in by the funeral director, name 2 chanted has a completed filled in by the funeral director. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 1 ∐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Tyes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSDICE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Chec dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Sigr ature and 29d. Date signed (Month, Day, Year) D0071287

DHMH 17 Rev 7/2009

State Registrar hill

Suite 4105, Baltimore

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Physician/ 2010 27 AM Dec. Gloria Oralee Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Med. Anne Arunde1 Center Glen Burnie 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 8. Date of Birth 5. Social Security Number **Funeral** 1 🗆 M 2 🕅 F Davs Hours Min. 9 (M9nth Bay, Mary land 83 1927 Director 214-22-3733 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important If Item 27 is marked other than "natural", or increase any injury or other trainmatic 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Director 1 🗌 Yes 2 💢 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 759 202nd 21122 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: 3 X Widowed 4 □ Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Produce Company Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jasper Phelps 0sa Jane Derner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Geldmacher / daughter 759 202nd St. Pasadena, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/11/2010 Glen Haven Mem. Park 21. Sign ture priva, eral ervice Licensee 22. Name and Address of Facility
Kirkley-Ruddick
421 Crain Hwy. Funeral Home, SE Glen Burni 9/1 21061 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final umonia Ph sician/ disease or condition Medical resulting in death) sequence of or as a Examiner Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or linjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Dav ☐ Pregnant at time of death☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 🗓 No 3 🗌 Probably 4 🗎 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed' 2 1 NO 1 🗌 Yes Yes 2 No 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 2 A N 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ဂ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending Accident 1 - Yes 2 🗌 No Investigation To the Funeral Director: Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title crtifie who completed cause of dea (Item 23a) (Type, Print) 30. Name and address of person

DHMH 17 Rev 7/2009

State Registrar Registrar's Signature

Mudisa

haty

DO

(4)

31. Date filed (Month, Day, Year)

10-09440					ible lnk. Ensur			egible		
Frank Thomasso	วท	State of 1- For State	of Maryland / Dep			nd Mental F	lygiene		2011	1 3915
		Registrar 1. Decedent's Name (First, Middle,Last)		erunc	ate of Death			Reg. No.		
Physicia Medical Exami		Frank Thomasson					2. Date of De Month	Day	Year	3. Time of Death 1605 hrs
***	1101	4a. Facility Name (if not institution, give	street and number)	-	4h City Town or	r Location of Deal	Decemb		County of Death	10001113
		809 Barkwood Road	street and number)		Glen Burnie		11		nne Arundel	
Funeral		Social Security Number 6. Sex	7. Age (In yrs	last hir			s 8 Date of F		DD/YYYY) 9. Birt	hnlace (State or
Director		216 22 2724		. Idot bii	Months Day		n.	,	Foreig	n
		1 2	A 2□F 81		Yrs.		Jan.	8, 1	929 60	^{untry)} Marylar
any		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town	or Location					10d. Inside City Limits
		Maryland Anne Art	ındel Gle	n Bi	urnie					1 Yes 2 X No
rylan a-fsl	cto	10e. Street and Number	010		10f. Zip Code			10a Citiz	en of What Cour	
e Ma or 28	Director	809 Barkwood Rd.			21061				ed State	,
215-0036 be filed within 72 hours after death with the Maryland nital Hyggene. rked other than "natural", or items 23a or 28s-f sho ent, the Medical Examiner must be notified at once.	<u> </u>		12. Was Decedent Ever in	11.5	13. Was Decedent of Hi	enanic Origin? / 9	necify Ves or N		14. Race - Ameri	
ath v	Funeral	1 Never Married 2 Married	Armed Forces?	0.0.	If Yes, specify Cubar				White, etc.	Sair Indian, Black,
ter de		3 X Widowed 4 Divorced	1 Yes 2 No		1 Yes 2 No	specify:			Specify: Wh:	ita
136 thin 72 hours after te. than "natural",	d b	15. Decedent's Education (Specify only	or Dates:	16a.	Decedent's Usual Occupa		work done		ind of Business/I	
2 ho	etec	Elementary/Secondary (0-12)	College (1-4 or 5+)	┨	during most of working life	e. DO NOT use re	tired)			,
thin the chica	ğ	12		Ma	aintenance			U.	S. Posta	al Service
5-0 ed wi	Completed	17. Father's Name (First, Middle, Last)				18.Mother's Nam	e (First, Middle	, Maiden S	Surname)	
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	å	Unknown			_	Unknown	1			
and 2 should lealth and Me (cm 27 is mater traumatic cv	မှ	19a. Informant's Name/Relationship (Typ			b. Mailing Address (Stree					
MD d 2 sho tth and a 27 is		Michael E. Priebe			8 Foxwell Be		Glen Bu			
re, M s 1 and 2 f Health if item 2		20a. Method of Disposition 1 X Burial 2 Cremation 3	_		of Disposition (Name of ce ory or other place)	metery, De	c. 14,	20c. L	ocation - City or	Town, State
MOCE Pages 1 ent of H int: If i		4 Donatton 5 Other Specify:			iew Mem. Pk.		010	Sy	kesville	e, Maryland
Baltimore, permit. Pages 1 a Department of He Important: If its injury or other to		21. Sure of Funeral Service License	e		22 Name and Address Kirkley-Ru	s of Facility	mamal I	Iomo	Τ) Λ	
E F P R W	- 1	1. the Kill			421 Crain	Hwy., S.	E., Gle	en Bu	rnie, MI	21061
Physician		23a. Part I. Enter the disease, or complice failure. List only one cause on each		th. Do no						Approximate Interval Between Onset and
/Medical		· · · · · · · · · · · · · · · · · · ·	therosclerotic Cardio	vascu	lar Disease Complic	cated by Necl	Injury and	Hypoth	ermia	Death Death
:Adiffiliei	ı	or condition resulting in death)	ue to (or as a consequence	of):						
		Sequentially list conditions, b								
	Ë.	cause. Enter Underlying Cause	le tu (or as a consequence	OTJ.						
.=	Examiner	TDISEASE OF INJURY MALIFIMATED	e to (or as a consequence	of):						-
ox 68760, eath certificate be executed artending physician and or use as the burial - transit	CalE	d								
oe exe		UNPENDED	AMENDED							
760 cate t	\$	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pre	gnancy				23d.	Date of delivery	
68 rertifi se as	Physician/Med	past 12 months?	1 Live birth 4 Pregnant at time of o	leath -		Ectopic pregn	ancy	1 '	Month D	ay Year
Sox 6 leath cer e attendi for use	Si	1 Yes 2 No 9 Unknown	9 Unknown	eath 5	Other (Specify)					
that the detected is		Part II. Other significant conditions o	ontributing to death but not	resulting	g in the underlying cause g	given in Part I.	23e. Did	tobacco u	se contribute to t	ne cause of death?
, P.O.	Completed by						1 🗌 Ye	es 2	No 3 Proba	ably 4 🗹 Unknown
rds, requir	iệ jệ						24a Was	s an	24b. Were aut	opsy findings available
COT law r has b	횰	-					auto	psy ormed?	prior to co death?	empletion of cause of
tal Recino: The certificate ector, page	ह						1 Yes	2 No	1 🗸 Yes	2 No
Vital Rec ysiciao: The his certificate director, page	å	25. Was case referred to medical examiner?	spital: 1 Inpatient 2	1		of Death (Check		,		
Physic ral dire	의	1 Yes 2 No 27. Manner of Death			utpatient 3 DOA Time of Injury 28c. Inju	ry at Work?			ce 6 🗸 Other:	Scene
Division of Vital Records, P.O. Box 68760, sa or Attending Physiciao: The law requires that the death certificate be rs after death. 11 Director: After this certificate has been signed by the attending physiciled in by the funeral director, page 2 should be detached for use as the buri	티	1 Natural 5 Pending	28a Date of Injury (Month, Day, Year) FOUND:	FOU		Yes 2 ✔ No	28d Describe Subject fell			exposed to low
SiOr Attend death. ector:	₩	2 Accident Investigation	Dec 8, 2010	1600	hrs		environme		<u> </u>	
Divisior piral or Attend ours after death teral Director:	Certification:	3 Suicide 6 Could not be determined			arm, street, factory, office b	building, etc.			Glen Burnie, N	al Route Number, City
Div Hospital or 24 hours afte Funeral Dis		29a Certifier	(Specify) Sidewalk							
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Sal	(Check only	 To the best of my knowle n the basis of examination 							
To the vithin To the complet	Medical		nd manner stated.		29c, Licens		-,		ate signed (Mon	
		1// 1 /	/ AIN		0.C.I				ember 9, 201	. ,,
		Mu Dlagnel	010	~ 00				2000		
		 Name and address of person who cor Melissa Brassell, MD Ass 	npleted cause of death (Ite istant Medical Exam		111 Penn Street, B	Baltimore MD	21201			
	240	31. Date filed (Month, Day Year)	32. Registrar's Signa		Sim Street, B					
31	ate	DEO 4, 20, 403, 40	A January Spira	MARI	Kar					

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 8:42 a M Month 12 Physician/ Day Addie Adeline Thompson 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Balto Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🖫 F Months Days Hours Min (Month, Day, Year) 6-10-1925 85 216-28-7536 Yrs Director Usual Residence of Decedent shov 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director ed other than "natural", or items 23a or 28a-f s event, the Medical Examiner must be notified Yes 2 No na Balto 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21214 3202 Wisteria USA Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 Black 1 Yes 2 No Specify 3 X Widowed 4 □ Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Board of Education Elementary/Seconday (0-12) College (1-4 or 5+) Balto, Co. should be filed with and Mental Hygien 8th grade Custidian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ment. Important if fem 27 is marked any injury or con-John Banks Anna Mosely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marian Johnson-Daughter 3202 Wisteria Avenue Balto, MD 21214 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Greenmount 1 Burial 2 Cremation 3 Removal from State 12-16-10 4 Donation 5 Other (Specify) Balto, MD March East F/H 21. Signature of Funeral Service 22. Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death hysician/ CONGESTIVE HEART FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-t Physician/Medical Box 68760 as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death the Unknown 9 🗌 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 2 🗌 No Yes 2 No 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 **X** No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending Division 2 Accident
3 Suicide
4 Homicide M 1 Tes 2 🗆 No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🛣 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUNECIA WHITE. CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

а.ш.

8:42

10,

December

Thompson

Addie

all

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#26perpHYS. G910, 12/13/2010, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Catherine Fallon Thomas Dec 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 1317 Willow Road Dunda1k Baltimore Co. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🛣 F Months Davs Hours Min. (Month, Day, eb. 22 **Director** 90 Pennsylvania 217-20-8516 Feb 1920 Usual Residence of Decedent marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MDBaltimore Dunda1k 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1317 Willow Road 21222 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 **X**No Yes Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes. Give 3

Widowed 4 □ Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mabel Veronica Lynch other traumatic Frank Leo Snyder permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 908 Aspen Lane Red Lion, PA Charles W. Thomas (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 🛮 Burial 2 🗌 Cremation 3 🗌 Removal from State Donation 5 Other (Specify) Sacred Ht. of Jesus Cem. 12/11/2010 Dundalk, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland Wise Ave. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final CARDIAL Onset and Death Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any leading clause. Enter Underlying Cause (Disease or iinjury Examine s been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant
9 Unknown Pregnant at time of death 5 Other (specify) Year Yes 2 No 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ METASTATIC Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perform death?
1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Vursing Home 5 X Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA s after death.

I Director: After this of in by the funeral di 27, Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, within 24 hours af To the Funeral Di completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0021859 121 9/16. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Taqui Shipping Place Dundalk, Maryland 32. Registraris Signature State Darke Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and Properties of Maryland / Department of Health American / Department of Health American / Department / Departmen	Mental Hyg	giene 0 1 0	39157
ı	Physici		1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	Day Year	3. Time of Death
The second second	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dec	ath	4c. County of Dea	th
	Funeral Director		5. Social Security Number 6. Sex 7. And (In yrs. last birthday) If Under 1 Year If Under 24 Hi Months Days Hours Min		9. Bir (, Year) 9. Co	thplace (State or Foreign
	yland now		Usual Residence of Decedent 10a. State			10d. Inside City Limits
	the Mar 28a-f sl	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	1 Pres 2 No
	23a or		12 N. Abinston Avenue 21229		USA	
5-0036	urs after des al", or items Exeminar m	by Funeral		(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	
21215-0	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinations to recified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of willife. DO NOT use retired)	orking	16b. Kind of Business	Industry
Maryland 2	should be filed and Mental Hygins marked other aumatic event, II	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's N Elean	ame (First, Middle,	Maiden Surname) hnson	
	1 and 2 sh Health and em 27 is m other traum		19a. Informant's Name/Relationship (Type. Grint) 19b. Mailing Address (Street and Number or of Street and Number of Street and Number of Street and Number or of Street and Number of Str	Aural Route Numbe	r, City or Town, State, .	Zip Code) 21229
altimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Date -3-2010	20c. Location - City or	are mD
Balti	permit. Page Department Important: II any injury or		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 25151 Baltymore	Nat'l Pi	Greene F- Ke Balto	uneral Services im) 21229
Line .	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ac or respiratory an		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequent of):			
	it d	iner	Sequentially list conditions, if any, leading of initial date cause. Enter Underlying Cause, (Disease or injury		(A	
30,	sath certificate be executed attending physician and for use as the burial-transit	ıl Examiner	Cause (Disease or injury that initiated events resulting in death) Last C			
	rtificate t ng physic as the b	fedical	d			
O. Box	law requires that the death cert as been signed by the attending 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 3 □ Ectopic pregnancy 5 □ Other (specify)		23d. Date of de Month	livery Day Year
ords, P.	w requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to es 2 ☑ No 3 □ P	o the cause of death? robably 4 🗆 Unknown
<u>۳</u>	n: The law n ficate has be r, page 2 sh	Completed		24a. Was a autop: perfor 1 □ Yes	sy prior to med? death? 2 ☑-No 1 ☐ Yes	utopsy findings available completion of cause of
f Vit	Physiclan: this certificaral director, p	To Be	examiner? — Hospital: Other:	eath <i>(Check only or</i> Home 5 ☐ Resid	<i>ne)</i> lence 6	ecify)
ion o	ath. ath. r: After the funeral	ation:	27. Manner of Death 1 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 8 Unique 1 State of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe h	ow injury occurred	
Divis	To the Hospital or Attending Physician: The living a Lours after death, within 24 hours after death, To the Funeral Director; After this certificate h completely filled in by the funeral director, page	Certification: To	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	treet and Number or R rn, State)	ural Route Number,
	Ro the Hospital within 24 hours a for the Funeral Completely filled	Medical	29a. Certifier (Check only one) Check only one) Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the check only one) An order of the check only one of the check one of the check only one of the check on	curred at the time, of	date and place, and du	e to the cause(s)
	withir comp	Me	29b. Signature end title of certifier 29c. License number	2	29d. Date signed (Mon	723/2010
	47		30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) EMNED P. Therman You help the Control of the State 1000 Coffns	nille, ND	ring	
ì	Sta Registr	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ IRENE WOOLSHLEGER J. 2010 11:45 PM DECEMBER Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GILCHRIST HOSPICE CENTER TOWSON 7. Age (In yrs. last birthday) 82 yrs. If Under 1 Year 5. Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 3 – 1 – 1 9 2 8 1 □ M 21 F Months Days Hours 215-24-2663 Director MARYLAND Usual Residence of Decedent show 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director N/A MD BALTIMORE 28a-f 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be Funeral 21213 3604 LYNDALE AVENUE U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: WHITE Completed 3X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME t. Page 1 and 2 should be filed with rment of Health and Mental Hygien rtant: If item 27 is marked other I niury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ GRYGLEWSKI CASIMER CARRIE SUMMERS) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1524 BRIAN ROAD ROSEDALE, MD 21237 19a. Informant's Name/Relationship (Type, Print) BRIAN WOOLSHLEGER/SON ROSEDALE, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department c Important: If any injury or 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STANISLAUS CEM 12-13-10 DUNDALK, 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityCVACH/ROSEDALE FUNERAL HOME ROSEDALE, 21237 1211 CHESACO AVE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying attending physician and I for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 Wo Month Dav Year Pregnant at time of death 5 Other (specify) Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown To Be Completed Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perforn 2 🗆 No 1 🗌 Yes Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer 1 Natural
2 Accident
3 Suicide 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours after To the Funeral Direc Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of npleted cause of death (Item 23a) (Type, Print)

State Registrar 82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Eleanor D. Wroten December 9. [□]2010 6:54 P. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore **Examiner** Town, or Location of Death 3331 Woodside Avenue Baltimore 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 578-10-4163 Days 1 ☐ M 2 ☐**X**F Months Hours 93 October 5. 1917 MaryTand Yrs **Director** Usual Residence of Deceden items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Baltimore 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3331 Woodside Avenue 21234 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 XWidowed 4 Divorced Specify 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Archiebald Dougherty Elizabeth Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3331 Woodside Avenue Baltimore Maryland 21234 Ronald Wroten/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Loudon Park Cemetery 12/14/10 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Leonard and Address of Facility no 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting In the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☐ No 2 -Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home ieral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗀 Yes 2 Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier dress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. I. Decedent's Name (Firşt, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Mandrin Chesapeake Hospice House Harwood Anne Arundel 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min Yrs Director 216-22-2580 81 Wovember 15, Maryland Usual Residence of Decedent shov and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shov or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Anne Arundel Crofton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 1715 Sturbridge Place 21114 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 2 No 1948-11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married 1 💢 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates.1952-1971 the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Grocery Store Management Grocery Store other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Glenn W. Whittington, Sr. Carrie L. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Margaret Lucille Whittington 1715 Sturbridge Place, Crofton, Maryland 21114 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State December 13 2010 west Arundel
Crematory 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Odenton, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Donaldson Funeral Home & Crematory
1411 Annapolis Road, Odenton, Mary Will Erone Maryland 21113 M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate AGEAL Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed' death? 1 🗌 Yes 21 1 Tes 2 No 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 M No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Sther (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending ...atural □ Accident □ Suic 1 Tyes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature, and title of cartifier 29c. License number 2010 30 Name and address of person who completed cause of death (Item 23a) (Type, Plint) HWY ANNAPOLIS M.D. 21401 DR VE GHTFOOT- LAYL

Registrar

State

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

32. Registrar's signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend, #22 State AMar Plan 69/ Bebarting of Health and Mental Hygiene Registrar#20b, 22perFH, G910, 12/14/10, WS Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Day 9:10 PM Walter James Whitlock December 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Apt "C" <u>Baltimore</u> <u>1313 Old Eastern Avenue</u> 7. Age (In vrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Min. Hours Mary land Director 219-42-1105 68 Usual Residence of Decedent f show ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 💢 No Maryland Baltimore Essex 10f. Zip Code 10g. Citizen of What Country? Funeral Apt "C" 1313 Old Eastern Avenue 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced "natural" Year or Dates White it of Health and Mental Hygiene.
If item 27 is marked other than "natur or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic <u> Automobile</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Whitlock Franklin Frances Brzevko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher Whitlock (Son) 1313 Old Eastern Avenue Essex, Maryland 21221 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department of Important: If any injury or Batview Crematory 12/10/2010 Baltimore, MD 22. Name and Address of Facility Signature of Fune Service License Ronald 8 Wide, Director 407 Old Eastern Avenue Essex, MD 2122 23a. Part 1 Enter the disease, or complications that caused shock, or beart failure. List only one cause on each line. is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Biventricular failure with Ischemic Cardianygrathu Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit HIN that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial fibrillation, COPD, CAD, Hypothy rodism 2 ☐ No 3 ☐ Probably 4 X Unknown Diabetes Mellitus type II 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 🗌 Yes 2 **X**No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 2 🗌 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) gidfain 12/08/2010 D0063640 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1124 MACE AUE, BALTIMORE, WD 21221. State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #4c Per PHY G910 12/13/10 Jh
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:15 PM 2010 Harry Weber December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ohns Hopkins Bayview (are Center Bathmore N7A Baltmore If Under 1 Year | If Under 24 Hrs. Sex 1 ₺ M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sept23, Year) 912 212-10-5534 98 Maryland **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Md. Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2108 Boston Street Apt 211 21231 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 7th Warehouse Supervisor Shipping Be 17. Father's Name (First, Middle, Last) (unk) (unk) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Josephine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2416 Whitt Road Kingsville, Maryland 21087 Earl Kahl (Nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Rosary Cem 20a. Method of Disposition December 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 13,2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility} Kaczorowski Funeral Home PA 1201 Dundalk Avenue Baltimore, Md. 21222 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ duplo history of Ventri cular tachycard Thou Acro mia Medical resulting in death) Due for as a synsequence of): Examiner years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury ard commoran that initiated events resulting in death) Last Due to (or as a comp quence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has performed 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) 2. No Other: ၉ 1 🗍 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 Matural 5 Pending Accident Investigation 24 hours after deatl Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c License number 2084 6 6 4 29d. Date signed (Month, Day, Year) pam verly 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) arche Baltmore MD 21224
Kimberly K. Vauahn 5505 Hopkins Bayview arche Baltmore MD 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 10 DEC Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Louis J. Winkler, Sr. Dec. 7, 2010 9:20 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 9 Hopkins Street Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Days Hours Oct. 26,1926 **Director** 212-22-4867 84 Maryland Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9 Hopkins Street 21061 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give 1 Yes 2 No Specify: Completed 3 Divorced 4 Divorced Year or Dates. WW II Decedent's Education. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Bottleing Company 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles William Winkler Elizabeth Waggner permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hopkins Street, Glen Burnie, Maryland 21061 Ellen M. Winkler, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Dec. 2010 cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Crownsville MD Vet. Cem. Crownsville, Maryland ure of Fur ral Service Lious e 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, 8 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death
Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year i signed by the aid be detached t Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 X No After this certificate funeral director, pag 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Hospital: 2 🖾 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation within 24 hours after death To the Funeral Director: / completed filled in by the? 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year, December 8, 2010

DHMH 17 Rev 7/2009

State Registrar Dominick J. Memoli, M.D., 808 Landmark Dr., Suite 128, Glen Burnie, MD 21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Rosalie Mae Yuhase 6:30P M December 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1709 Pin Oak Avenue Dundalk Baltimore Co. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye. Months Days Hours Min Country) Maryland 1 M 2 K F Director 70 214-38-6278 Ĩ940 Aug. Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2X No MD Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1709 Pin Oak Avenue 21222 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2x ☐ No Specify: Specify Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Own Home Homemaker Be Unkn. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George H. Grace 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1709 Pin Oak Avenue Dundalk, Maryland 21222 19a. Informant's Name/Relationship (Type, Print) Mr. Peter T. Yuhase (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Holly Hill Mem. Gdns. 12/9/2010 1 Burial 2 Cremation 3 Removal from State Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Euneral Service Li 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Dundalk, Maryland Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Non Small Q Medical resulting in death) Due to (or as a con ecuence of): Examiner Sequentially list conditions, Examiner Due to (or as a consecuence of) cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last use as the burial-transi ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director; After this certificate has autopsy performed' 2 No 2 1 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 No Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Description Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) sailain Ner 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltemore MD2123 hospetal Suite 208 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 10e State of Maryland 12/24/2011 diff Health and Mental Hygiene For At State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 22, 2010 Year Patrick Addey Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Montgomery Hospice-Casey House Derwood Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Min. 1 🛂 M 2 🗆 Hours Feb. 27, 1958 Director 226-73-4462 Yrs Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director MD Montgomery Germantown 10e. Street and Number 10f. Zip Code Circle 10g. Citizen of What Country? Funeral 13602 Palmetto Drive 20874 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by 1 Never Married 2X Married 1 ☐ Yes If Yes, Give 2 🗷 No 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Theophilus Addey Beatrice Opoku

Physician/ Medical Examiner

burial-tran

attending physician for use as the buria

signed by the a d be detached f

cate has been signated by page 2 should by

after death.

Director: After this certificate

pleted filled in by the funeral director,

Examin

Physician/Medical

Completed by

Be

မ

Certificate:

Medical

IF FEMALE:

Sequentially list conditions, it any leading to in the dist cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months?

1 Yes 2 No

25. Was case referred to medical

1 ☐ Yes 2 🗷 No

27. Manner of Death

Natural

4 Homicide

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

Accident

Suicide

Immediate Cause (Final

disease or condition

resulting in death)

20a. Method of Disposition

5 Pending

6 🗌

Investigation

Could not be

determined

19a. Informant's Name/Relationship (Type, Print)

1 Burial 2 Cremation 3 Removal from State

Carolyn Lavon Addey/Wife

4 □ Donation 5 □ Other (Specify)

21. Signature of Funeral Service Licensee

23c.	If yes,	outcome	of	pregnano

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of injury (Month, Day, Year)

3 Certifying Nurse Practioner: To the best of my knowledge,

Live Birth 2 - Fetal death 4 🔲 Pregnant at time of death 9 Unknown

Due to (or as a consequence of):

Due to for as a consequence of:

Due to (or as a consequence of):

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____

20b. Place of Disposition (Name of

All Souls Cemetery

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List on cause on each line.

cemetery, crematory or other place)

Cancer with Unknown Primary and Metastasis to the Liver

23d. Date of delivery Dav

23e. Did tobacco use contribute to the cause of death? 24a

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2010

500 University Blvd.W., Silver Spring, MD 20901

Date

4, Lec.

13602 Palmetto Circle, Germantown, MD 20874

22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.

26. Place of Death (Check on

D37142

Other:

28c. Injury at

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ndings available

. Was an autopsy performed? Yes 2 ፟፟፟፟፟፟ No	24b. Were autopsy fi prior to complet death? 1 \sum Yes 2 \sum
•)	

tion of cause of No

1 L Yes 2 LA	No I L Yes 2	L
ly one)		
	Hospice	_
5 Residence	6 K Other (Specify)	

Other: 4 \(\sum \) Nursing H	lome	5 Residence	HOSPIC 6 X Other (Speci
Injury at work? 1 ☐ Yes 2 ☐ No	28d.	Describe how inj	ury occurred

	28d. Describe how injury occurred
0	

28f. Location (Street and Number or Rural Route Number City or Town, State

November 22, 2010

1 X	Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌	Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
	Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number 29d. Date signed (Month, Day, Year)

ddress of person who completed cause of death (Item 23a) (Type, Print)

Hospital

Geoffrey Coleman, MD 1355 Piccard Drive, #100, Rockville, MD 20850

State Registrar 31. Date filed (Month, Day, Year NOV 2 6 2010

1 Inpatient 2 ER/Outpatient 3 DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

injury

4c. County of Death

USA

Montgomery

Ghana

14. Race - American Indian Black, White, etc.

16b. Kind of Business Industry

20c. Location - City or Town, State

Germantown, MD

Elack

Shipping & Copying Services

Approximate Interval Between Onset and Death months

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 🗌 Yes 2 屎 No

12:55 р м

Baltimore, Maryland 21215-0036

Box 68760 P.O. Division of Vital Records,

certificate be executed

Hospital or Attending Physician: 24 hours after death. 24 hours To the within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician/ Maurice Dennis Alexander November 6:56 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5805 42nd Ave #720 Hyattsville Prince George's Social Security Number 7. Age (In yrs. last birthday) f Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Month, Day, Year b 28 1 Months Hours Min. 1**X** M 2 □ F 84 Director 578-88**-**0634 Grenada Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Hyattsville Prince George's 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 5805 #720 20781 42nd Ave USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ Yes 2X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify. Completed 3 Divorced 4 Divorced Specify: Black Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) George Washington University Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ralph Alexander Agnes Noel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5805 42nd Ave #720 Hyattsville, Md Edith Alexander / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🗀 Removal from State permit. Page Department of Important: If any injury or once, Fort Lincoln Cemetery 11/26/10 Brentwood, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se 22. Name and Address of Facility Fort Lincoln Funeral Home Tarcis 3401 Bladensburg Rd Brentwood, Md 20722 , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Part 1. Enter the diseas Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final Physician/ Multiple Organ Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Cirrhosis of the Liver Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury Alcoholism many yrs ago physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ģ Month Year Pregnant at time of death 5 Other (specify) Day been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available page 2 prior to completion of cause of death? autopsy performed? certificate has 1 Yes 2 No Yes 2X N 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 K Residence 6 C Other (Specify 2 🛛 No 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 1X Natural 5 Pendina after death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52706 11/23/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Yea State Registrar

2010

Ashenati Waktola, M.D. 5806 Baltimore Ave. 32. Registrar Signat re

Hyattsville, MD

AKINLOLY 10-08865 ALABI

UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2010 39 State of Maryland / Department of Health and Mental Hygiene

		For State	Certifi	icate of		, a monta	, 0	g. No.		
Physiciar	1/	Decedent's Name (First, Middle,Last)					Date of Death Month	Day Year		3. Time of Death
Medical Examin		AKINLCLU G. ALABI					Month November			0112 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death SB Baltimore Washington Parkway north of Rt 197 Laurel 4c. County of Death Laurel Prince George's						's		
Funeral		Social Security Number 6. Sex	7. Age (In yrs. last b		If Under 1 Ye	ear If Under 2	4Hrs. 8. Date of Birth			nplace (State or Foreign
Director		220-73-1138 1XM 2		Yrs.		ays Hours	Min. NOV. 2	,		ERIA
, fu	- 1-	Jsual Residence of Decedent 0a. State 10b. County	10c. City, Tow	vn or Location	1					10d. Inside City Limits
how s	.	MD PRINCE GEORG	E'S BOWI	E						1 XYes 2 No
arylar	Director	0e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	at Coun	try?
th the M 23a or 2 notified		12909 5TH STREET 20720						USA		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Inti. If time 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married Arme		If Yes	, specify Cub	an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - White,		an Indian, Black,
s after ral", niner	合	Widowed 4 Divorced If Yes, Given or Dates:			es 2 X N			Specify:		ACK
hour "natu	일-	15. Decedent's Education (Specify only highest Elementary/Secondary (0-12) College	grade completed) 16a			ation (Give kind fe. DO NOT use		16b. Kind of Bus	iness/ir	idustry
336 thin 72 than than edical	Completed	2+		STUDEN	JТ			PRIVATE	7.	
5-0C ed wii lygien other	51	7. Father's Name (First, Middle, Last)		01000		18. Mother's N	ame (First, Middle, M			
21215-0036 und be filed within 7 Mental Hygiene marked other than c event, the Medica	g	OLUWATOMISIN FELIX A					IARY MONYE			
Should Me is me affice	^ا≏	9a. Informant's Name/Relationship (Type, Print					or Rural Route Numb			Zip Code)
, MD and 2 sho ealth and em 27 is	ŀ	ROSEMARY ALABI/MOTHER Oa. Method of Disposition			5TH ST on (Name of c		Date MARY	LAND 207 20c. Location - 0		own State
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If litem 27 is marked other injury or other traumatic event, the Med		Burial 2 Cremation 3 Remov	al from State crem	atory or other	r place)	·			•	·
Itim it. Pa rtmen rtant y or o	-	Donation 5 Other Specify: Signature of Fune 1 Service Licensee	RESU				2/3/2010			RYLAND HOME, INC.
Balt permit. Depart Import		. Signature of Fuller 13 Vice Licensee								LAND 20785
Physician	1	3a. Part I. Enter the disease, or complications the	at caused the death. Do							Approximate Interval
/Medical Examiner		failure. List only one cause on each line. mmediate Cause (Final disease or condition resulting in death) a Multiple Due to (or	Injuries as a consequence of):							Between Onset and Death
		sequentially list conditions, b								
ted Insit		ause, Enter Underlying Cause	as a consequence of):							
freate be executed g physician and the burial - transit	LXa	vents resulting in death) Last Due to (or d.	as a consequence of):							
be exe	Medical	UNPENDED	D							_
ficate be		th Mas decedent program in the	es, outcome of pregnanc		2	Catania and		23d. Date of d	,	V
Box 687 e death certific the attending p ed for use as th	rnysician,	past 12 months?	regnant at time of death		death 3 (Specify)	Ectopic pre	gnancy	Month	Da	ay Year
BO)	<u>-</u>	Yes 2 No 9 Unknown 9 U	nknown							
P.O. es that the igned by be detach	5	art II. Other significant conditions contribution	ng to death but not resulti	ing in the und	lerlying cause	given in Part I.			_	ne cause of death?
ords, P w requires the state of	<u> </u>						24a. Was ar			opsy findings available
corc	립						autopsy perform	, pri		mpletion of cause of
ician: The certificate rector, page	nenduno						1 ✓ Yes 2		/ Yes	2 No
ital sician:	ŭΙ	5. Was case referred to medical examiner? Hospital:	Inpatient 2 ER/	Outpatient 3		Other Nu		esidence 6	Othor	Coope
of Ving Physical After this uneral direction	2 2	1 V Yes 2 No 28a D	ate of Injury 28b	. Time of Inju		ury at Work?	28d. Describe ho			Scerie
Division of Vital Records, spital or Attending Physician: The law require uturns after death. Ineral Director: After this certificate has been si filled in by the funeral director, page 2 should be certificated.		Feliding		UND: 55 hrs	1	Yes 2 ✔ No	Pedestrian st	ruck by auto	S	
viSicor Attraction Director in by t	3		19, 2010 008 Place of Injury - At home		factory, office	building, etc.			or Rura	al Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	<u> </u>	- determined	ify) Major Road / H	Highway_			or Town, Sta SB Baltimore W	^{te)} /ashington Pkv	vy , La	urel, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Certification: To Bo Completed by the Divisional Experimental Certification and the complete of the control of t		9a. Certifier 1 Certifying Physician: To the bank only 2 Medical Examiner: On the bank on the bank of	sis of examination and/or							
To wil	<u> </u>	and mann 9b. Signature and title of certifier	ei stated,		29c. Licen	se number		29d. Date signed	(Mont	h, Day.Year)
		man, us			0.0	.M.E.		November 1	9, 201	10
2 1	1	D. Name and address of person who completed								
- 0		Ling Li, MD Assistant Medical E			Baltimore,	MD 21201	 			
Stat Registra		NOV 3 0 2010	Registre's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle 1 ast) 2. Date of Death 3. Time of Death Physician/ 11-17-2010 Carlos Fredy Contreras Argueta 1430 D Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Cheverly Prince George Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g, Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 **X** M 2 □ F Days Hours Min Months 08-01-1966 44 El Salvador Director 212-61-8124 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b, County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 😾Yes 2 ☐ No Montgomery Silver Spring MD 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 1921 East West Highway 20910 El Salvador 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White etc. ò 1 Never Married 2X Married "natural", or 1X Yes 2□No Specify: salvadoran Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: Hispanic Completed 3 Widowed 4 Divorced er than "natur , the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 3rd Laborer Construction is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Rosa Contreras Alvarez Timoteo Argueta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Carlos Argueta Alvarez 1921 East West Highway #204 Silver Spring, MD 20910 (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Family Cemetery 12-06-10 El Salvador 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. 3447 14th St. N.W. Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition) Medical resulting in death) Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate Yes Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) funeral Monner of Death 28b. Time of Certificate: 28c. Injury at injury 3° M 5 Pending Natural work? 1 ✓ Yes 2 ☐ No 2 Accident November 15, 7010 n 24 hours after death e Funeral Director: A pleted filled in by the f Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 400 Benning 4 Homicide determined di outs/de Medical Certifying Physician: To the best of my knowledge, death occured at the tode, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 3 🗆 only one) 29b. Signature and title of certifier 0 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Month, Day,

Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 26. ^Y2701 (Robert Michael Arciprete 6:10 ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, 1 **X** M 2 □ F Months Davs Hours Min. washington. Director 73 578-48-7117 May Usual Residence of Decedent i show : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 15120 Middlegate Road 20905 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? 1 X Yes 2 No 1955-Black, White, etc. 1 Never Married 2 X Married Beltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced 1961 Caucasian Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
Chief ON Parties Planning &
Development 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Parks & Recreation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Michael Paul Arciprete Rose DiPierri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia E. Arciprete - Spouse 15120 Middlegate Road, Silver Spring, Maryland 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/01/2010 | Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 21. Signature of Funeral Service Lige 22. Name and Address of Facility Hines-Rinaldi Funeral Home, ala 11800 New Hampshire Ave., Silver Spring, MD 20904 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1, Enter the disease Approximate Interval Between Onset and Death shock, or heart failure. List Lone cause on each line Immediate Cause (Final Physician, PNEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 5EP515 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the Innerial director, page 2 should be detached for use as the burial-transit LYMPHOMA Cause (Disease or linjury that initiated events Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: မ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) HOSPITALIST 10 D0059414

Registrar
DHMH 17 Rev 7/2009

State

18101 Prince Philip Drive, Olney, Maryland 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vladimir M. Rakhmanin,

31. Date filed (Month, Day, Year)

M.D.,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Physician/ Year ISIDRA MONTESINES AGBADA NOV 25 6:30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, May 15, 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Philippines 388-04-5854 $\overset{\scriptscriptstyle(ear)}{1}929$ Yrs. Director May 81 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Baltimore Perry Hall Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9306 Indian Trail Way 21128 Philippines 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: Filipino 1 ☐ Yes 2 No Specify: 3 ☒ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Melecio Montesines Maria Montiel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonora Milan / Daughter 9306 Indian Trail Way Perry Hall, Maryland 21128 20a. Method of Disposition 20c. Location - City or Town, State Paete Laguna, Philippines 20b. Place of Disposition (Name of December 2010 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Municipal Cemetery 21. Signature of Funeral Service Lab Name and Address of Facility
obert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc.
557 Wisconsin Avenue Bethesda, Maryland 20814 M01607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final NON SMALL CELL LUNG CANCER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 X No Pregnant at time of death Month Day Year been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Yes 2 K No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🔀 No 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred **X**Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifie A 9900650 (NC) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER COLLEEN DORRANCE CDR MC USN BETHESDA MD 20889-5600

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene RegistaMEND#19aperINF, 11/30/2010, BWW, McCo Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Rachel Brooks Month November 24, 10:11 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice-Casey House Derwood Montgomery Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Director 183-14-5908 88 Aug. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits items 23a or 28a-f 1 Yes 2 X No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16428 Fox Valley Terrace 20853 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black White etc. ō Completed by 1 Never Married 2 Married 1 Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₺ No Specify: Specify: White "natural", 3 🗌 Widowed 4 🗀 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) id Mental H marked of ည Louis Schap Catherine Adams permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant Name/Relationship (Type, Print)
Marcus Brooks/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16428 Fox Valley Terrace, Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State Nov. 27 2010 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring Signa of Funeral/Service 23a. Part 1. Enter the disease, or compli ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Interval Between Immediate Cause (Final Onset and Death Physician/ Intracranial Hemorrhage disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or impury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Other (specify) Month Dav Year 1 ☐ Yes 24 9 ☐ Unknown been signed by the should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Congestive Heart Failure, Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas performed? within 24 hours after death,

To the Funeral Director: After this certificate I 1 🗌 Yes 2 🗆 No Yes 2X No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No funeral director, Be 26. Place of Death (Check only one) Hospital Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1X Natural 5 Pending 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatiú 29c, License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

1355 Piccard Drive, Rockville, MD 20850

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Debrah Miller, CRNP

NOV 26

31. Date filed (Month, Day, Year,

R143201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Maryla		artment of F tificate of L	Health and N		21		39172
		-	Registrar 1. Decedent's Name (First, Middle	e. Last)		Cer	uncate of L	Jean	2. Date of Dea	Reg. No.	, 0	3. Time of Death
	Physicia		Ethel Louise E	, ,					Month	27 27	2010	12: 45A ^M
-and	Medic Examin		4a. Facility Name (if not institution	-	nber)		4b. City, Town, or	Location of Death			y of Death	12: 1311
wa.	,		Seasons Hospic	e				dallstown	l.		Balt	imore
	Funeral Director	13	5. Social Security Number 400-60-3618	6. Sex 1 ☐ M 2 X F	7. Age (In yrs.	last birthday) SYrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 11/27	h //Year)	g. Birthpl Counti	
			Usual Residence of Decedent			50			11/2/	/1942	1	KY
	rland F shov	tor	10a. State 10b. County		10c. C	ity, Town or Lo	cation				10	d. Inside City Limits
	Many 28a-i	Director		ard		Jessup						1 ☐ Yes 2X No
	ith the	rai	10e. Street and Number 8322 Barkwo	od C+			10f. Zip Code 2079	2.4		10g. Citizen of		*
	ems 2	Funeral	11. Marital Status		edent Ever in U		Vas Decedent of Hi	ispanic Origin? (Sp	ecify Yes or No-		ed Sta	
စ္	fer de , or it	by F	1 Never Married 2 Mar		2 XNo	li li	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Bla	ick, White, e	
003	ours af tural" al Exe	Completed by	3 X Widowed 4 □ Divorced	.00. 01 2	ates.		☐ Yes 2 XNo			Specif	whi	te
75	72 hc n "na Aedic	nple	(Specify only high	nt's Education est grade completed		(Give I	lent's Usual Occup kind of work done o O NOT use retired)	ation during most of work	ing	16b. Kind of E	Business Ind	ustry
212	within giene.	Col	Elementary/Seconday (0-12)	College (1	1-4 or 5+)		Homemaker	2		Ow	n Home	2
pu	filed all Hyge d oth	b Be	17. Father's Name (First, Middle,		-	-		18. Mother's Nam		Maiden Surnan		
yla	uld be I Ment narke natic	욘	Luckes Johnso			-		Bett	ie Risor	<u> </u>		
Mai	2 shoi th and ?7 is n traun		19a. Informant's Name/Relations			1		and Number or Run		-		
٠,	Healf Healf tem 2		Kim Boyle - D 20a. Method of Disposition		20b.	Place of Dispo	Johnsvil sition (Name of		Eldersbi	irg MD 20c. Location		
mo	page lent of nt: If in vor		1 ☐ Burial 2 🏻 Cremation 4 ☐ Donation 5 ☐ Other (State A		natory or other place Cremation	e)	29/10		ver, M	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service I			22	. Name and Addres	ss of Facility Ha	rry H. V	Vitzke':	s Fami	ly F.H. In
m	9 7 7 6 9			w- Wife	1						City,	MD 21043
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that only one cause on ea	caused the dea ach line.	th. Do not ente	7			est,		Approximate Interval Between
in the con-	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a	retarta	the l	eing Co	eccinom	Ca		>	Onset and Death
	Examiner		3	Due to	(or as a o nsec	quence ot):	*					
		iner	Sequentially list conditions, if any, leading to immediate	L. Due to	(or as a consec	quence of):						
	cuted nd ransit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
	ate be executed bhysician and the burial-transit	alE	resulting in death) Last	Due to	(or as a consec	quence of):						
760				d								
Box 687	requires that the death certifica been signed by the attending p should be detached for use as is	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregn	ancy	Ectopic pregnanc			23d. Da	ate of deliver	y
Box	death	sicia	in the past 12 months? 1 Yes 2 No		nant at time of		Other (specify)	;у		М	onth [Day Year
P.0.	it the of	Phy	9 ☐ Unknown Part II. Other significant condition			culting in the u	nderlying cause giv	en in Part I	00- Bide			cause of death?
ν. σ.	es tha signed I be d	d by	Tak II. Other significant conclus	ons contributing to c	death but not re	sulting in the u	idenying cause giv	remmart,			. 1	ably 4 Unknown
g	requit been s should	etec							24a. Was a			<u>.</u>
Division of Vital Records,	The law cate has page 2 t	Completed by							autop perfor	rmed?	death?	sy findings available pletion of cause of
a B	an: Th tifficat tor, pa	Be C	25. Was case referred to medical				26. Pla	ace of Death (Chec		2 No	1 ☐ Yes 2	2 □ No
Ž	Physician: T this certifica ral director, p	To E	examiner? 1 Yes 2 No	Hospital:	Inpatient 2] ER/Outpatien	t 3 DOA Othe	er: 4 Nursing Ho	ome 5 🗆 Resid	lence 6 Oth	Y LATEL ver (Specify)	it hispure
) of	ling P	ate:	27. Manner of Death 1 Natural 5 ☐ Pendir	28a. Date (Mon	of injury oth, Day, Year)	28b. Time of injury	28c. Injury work	?	28d. Describe h	ow injury occur	red	,
Sior	death ctor: /	Certificate:	2 ☐ Accident Investi 3 ☐ Suicide 6 ☐ Could	not be	of Injury - At h	ome farm stre	M 1 LI et, factory, office	Yes 2 ☐ No	28f. Location (S	treet and Numb	oer or Pural F	Poute Number
Ξ	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral		4 ∐ Homicide detern		ing, etc. (Specif		,,		City or Town		or or riurar r	ioute ruiribei,
	ospita houra unera	Medical	29a. Certifier 1 Certifying (Check 2 Medical I	Physician: To the b	pest of my know	vledge, death o	ccured at the time,	, date and place, ar	nd due to the cau	use(s) and man	ner as stated	se(s) and manner stated.
	the H hin 24 the F mplete	Me	cely one) 3/2 Certifying	Nurse Practicner			eath contimed at the	time, date and plan	ne, and due to the	ndus (a) veutro	ernar es stet	ed .
_	or witing €		295. Signature and title of certifie	lest			29c. License	1327	['	29d. Date signe	d (Month, D.	ay, Year)
	1		30. Name and address of person	who completed caus	se of death (Iter	n 23a) (Tyne P	eint Atnix	0 1 1		1-1	100	7 10
Çi	le		KAKEW W M	AU177	2835	Smil	TAVE.	Soute 2	13 /mi	More	, MI)	4269
	Stat		31. Date filed (Month, Day, Year)	2010 32.5	egistrar's Signa	ature			· ·			•
Į.	Registra	ir	INUVA	7 2010 /	yesean	p. 10.	arked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			Chate	partment of Health and N	Mental Hygie	ene	
			Registrar	ertificate of Death	Reg	. No. 2010	39173
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
Janes.	Medic		Bertha Catherine Bryan 4a. Facility Name (if not institution, give street and number)	1 0 T 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	November	28 2010	0906AM
	Examir	iei	Washington County Hosptial	4b. City, Town, or Location of Death		4c. County of Death	Country
П	Funeral	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth	Washington 9. Birthpla	ace (State or Foreign
п	Director		216-22-1710 1 M 2 XF 82 Yrs.	Months Days Hours Min.	March 27	,1928 Mary	Land
	nd now at	Ļ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		l to	11.11.02.11.22
	arylar a-fsl	Director	Maryland Washington County Hagersto				d. Inside City Limits 1 X Yes 2 □ No
	or 28 or 08 or otl			10f. Zip Code	100	. Citizen of What Countr	
	with 1	Funeral	350 Central Ave.	21740	109	U.S.A.	y:
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at			. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - American	ı Indian,
36	after or	Ş	1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puèrto 1 ☐ Yes 2 ☒ No Specify:	rican, etc.)	Black, White, et	
8	ours atura cal E	Completed	3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates. 15. Decedent's Education 16a Dec			Specify: Whi	Le
715	an "n Medi	E I	(Specify only highest grade completed) (Giv Elementary/Seconday (0-12) College (1-4 or 5+) life.	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ng 16	b. Kind of Business Indu	stry
2	withii giene er th , the		Elementary/Seconday (0-12) College (1-4 or 5+) Block	ker	1	Ribbon Comp	any
nd	be filed v lental Hyg rked oth	To Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		
Z	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	-	Phillip A, Shatzer	Mary Sha			
Ma	ge 1 and 2 should be file nt of Health and Mental I :: If item 27 is marked o or other traumatic eve			ling Address (Street and Number or Rura			de)
ē,	and Heg tem		20a. Method of Disposition 20b. Place of Disp	Central Ave. Hager			01.1
altimore, Maryland 21215-0036	permit. Page 1 Department of Important: If it any injury or o		1 X Burial 2 Cremation 3 Removal from State cemetery, cre	wn Mem. Park 12-1		c. Location - City or Tow	
ä	mit. F partm portal / injui			22. Name and Address of Facility Do		agerstown,	
m	De and			1331 Eastern Blvd.			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac c	r respiratory arrest,	Α.	pproximate
	nysician/		Immediate Cause (Final disease or condition	HEMORRHAGIC	SHOCK	(0	nterval Between Onset and Death
	Medical Examiner					a	W. W. W.
		er	Sequentially list conditions, if any, leading to infinediate	VCER			
	ted nsit	Examine	cause. Enter Underlying Cause (Disease or linjury				
	execu in and ial-tra	Exa	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
09	To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical	d				
687	rtificat ing ph e as th		IF FEMALE:				
×	ith ce ittend or use	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3			23d. Date of delivery	
P.O. Box	re des	Physician/M	1 Yes 2 No 4 Pregnant at time of death 5 Unknown 9 Unknown	Other (specify)		Month Da	ay Year
у О	that the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to the	cause of death?
S,	n sign	Completed by	CHRONIC OBSTRUCTIVE PULMOI	VARY DISTAGE	1 X Yes	2 No 3 Probab	oly 4 🗆 Unknown
Vital Records,	w requires bee	plet			24a. Was an	24b. Were autopsy	
ě	The la ate ha	ĕ			autopsy performed	? death?	letion of cause of
ē	cian:		25. Was case referred to medical examiner?	26. Place of Death (Check		THO TES 2	ANO
2	Physic this co	유	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Other: 4 Nursing Hor	me 5 Residence	6 ☐ Other (Specify)	
n ot	ding F h. After funer	Certificate:	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury	work?	8d. Describe how in	jury occurred	
SIO	Atten r deat ctor: y the	ij	2 Accident Investigation 3 Suicide 6 Could not be 4 Hemicide determined 28e. Place of Injury - At home, farm, str	M 1 ☐ Yes 2 ☐ No	20f Location (Otreat	and Number - Duri D	under Administra
DIVISION	al or / s after il Dire		4 ☐ Homicide determined 28e. Place of Injury - At nome, farm, sti building, etc. (Specify)		City or Town, Sta	and Number or Rural Ro ate)	oute Number,
	lospit hour unera ed fille	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or investigation)	occured at the time, date and place, and	due to the cause(s)	and manner as stated.	
	the H hin 24 the Fi		only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	death occurred at the time, date and place	the time, date and pla e, and due to the caus	ace, and due to the cause se(s) and manner as stated	(s) and manner stated.
	<u>ु ५ ४ म</u>		29b. Signature and title of certifier	29c. License number		Date signed (Month, Day	
9	•		repar mis	0058181	NOU	EMBER 30	,2010
DH	1-2		30. Name and address of person who completed cause of death (Item 23a) (Type, I	ETAM ST. #306			
6	Stat	e	31. Date filed (Month, Day, Year) 32. Legistrar's Signature	- 1111 311 7200	MUKSI	- 101 Y 111 Y	1140
	Registra		DEC 01 2010 A	and the same of th			

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 19 2010 10:15 AM ANNIE W. BLOUNT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death PRINCE GEORGE'S ADELPHI NEWBEGIN CARE HOME 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔀 F Hours Min. Months MARCH Day 6 1915 NORTH CAROLINA Director 579-22-6536 95 Usual Residence of Decedent 28a-f shov 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at **Completed by Funeral Director** ty∑ Yes 2 ☐ No PRINCE GEORGE'S ADELPHI MD 7 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 2200 SARANAC STREET 20783 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No ARMY If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced BLACK Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Elementary/Seconday (0-12) GOVERNMENT CLERK other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ဂ Page 1 and 2 should be PENNY GEORGE WILLIAMS STATON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar Important: If item 27 Is any injury or other trau once. 6006 WALNUT STREET TEMPLE HILL, MARYLAND 20748 DELORES HAYMAN/NIECE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State FT. LINCOLN CEMETERY 11/30/2010 BRENTWOOD, . MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee J. B.JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ CEREBRAL VASCULAR ACCIDENT Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last sician a Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death Yes 2 XNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2√ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2X No 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Yes 2 DXNo GROUP HOME 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 \square Pending Natural 1 🗌 Yes Accident Investigation in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 24 hours af Funeral Dieted filled in Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) NOVEMBER 22 2010 Physician D61067 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SILVER SPRING, MARYLAND 20904 LAURA D.

31. Date filed (Month, Day, Year) 12520 PROSPERITY DRIVE # 320 KHANDAGLE M.D. 32. Registra State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19 and Maryland Department of Health and Mental Hygiene 10-08862 Kathleen Bering 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 2135 hrs **Medical Examiner** BERING November 18, 2010 KATHLEEN 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Hagerstown Washington Washington County Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number **Funeral** Months Days Hours Min. Director 55 Country) 2 X F 438-98-2005 1 M 02/26/1955 Yrs T.A Usual Residence of Decedent 10b. County St. John the Baptist 10d. Inside City Limits 10a, State 10c. City, Town or Location LaP1ace Yes 2 X No s 23a or 28a-f show s notified at once. MD_ LA ashington Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 805 Mallard ST. USA East Chapli 70068 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married Yes If Yes, Give Year 3 Widowed 4 Divorced 1 Yes 2 X No specify: Specify: Black ş 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 12th Homemaker 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Freddie Donald Willie Mae Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shuntrell Bering - Daughter 805 Mallard St. LaPlace, LA. 70068 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place)
. John Memorial 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify 11-24-2010 LaPlace, LA Garden Cemeterv 21. Signature of Funeral Service Licen-22. Name and Address of Facility
Marshall-March Funeral Home of Maryland
4308 Suitland Rd. Suitland, MD 20746 Approximate Interval 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and Modical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last physician and the burial - transi Hospital or Attending Physician: The law requires that the death certificate be executed hysician/Medical UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the 1 Live birth Month 3 Ectopic pregnancy Day Year ned by the attending detached for use as 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown P.O. 立 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 Unknown DM, Obesity Completed Records, certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed page Yes 2 ✔ No 1 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be examiner? Hospital: 1 Inpatient 2 PER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other: this 1 V Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification 1 🗸 Natural Division 1 Yes 2 No Pending the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) within 24 hours a To the Funeral I determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

UR 5

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Register's Signature

Pamela E. Southall, MD

31. Date filed (Month, Day, Ye NOV 3 0 2010

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

November 19, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 21, 2010 Physician/ Marylee Buchly 7:42 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11709 Morning Glory Place Frederick New Market 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Da Months 1 □ M 2**X** F 062-03-2838 Director 92 1918 D.C Usual Residence of Deceder or 28a-f show s notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Frederick New Market 1 🗌 Yes 2 🗓 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? þe 23a Funeral must 11709 Morning Glory Place 21774 USA and Mental Hygiene.
ris marked other than "natural", or items
raumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Yes 2 X No Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes XX No Specify White 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 2 Administrative Secretary Fducation 1 and 2 should be filed w of Health and Mental Hygi item 27 is marked othe Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Lee Sterling Price Maude Ella Burdette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Buchly/Son 3119 14th Street, South Arlington, VA 22204 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 permit. Page 1 Department of I Important: If it any injury or o cemetery, crematory or other place) 1 😾 Burial 2 🗌 Cremation 3 🗍 Removal from State Nov. 30 2010 4 Donation 5 Other (Specify) Fort Lincoln Cemetery Brentwood, MD 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W., Silver 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ∲nysicien/ Respiratory Failure Medical resulting in death) Due to (or as a consequence of) Examiner COPD 6 yrs Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? iis certificate has been signed l director, page 2 should be det Completed by Dementia 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 🔁 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 24 hours after death.

Funeral Director: After this leted filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury 1x Natural 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) Nov. 24, 2010 ach Duck MD0000 13451 30. Name and address of person who completed cluse of death (Item 23a) (Type, Print) 3119 14th Street, South Arlington, VA 22204 Mark Buchly, MD 31. Date filed (Month, Day, Year) State 23 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Zº ID 2 Day Physician/ Braden Frank Wheeler 3:35 PM Medical 4a. Facility Name (if not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Howard Howard County General Hospital Columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Min. Months Hours Feb. 22, 1933 146-26-5847 NJ Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 Yes 2 X No MD Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ed other than "natural", or items 23a on event, the Medical Examiner must be Funeral 7305 Brookview Road 21075 USA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2x Married 1 XYes If Yes, Give <u>6</u> 2 - No Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. Specify White 3 Widowed 4 Divorced Year or Dates. 1955-63 Completed 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Attorney Law marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F ပ Francis W. Braden Irene Brown other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trai Joan K. Braden/Wife 7305 Brookview Road, Elkridge, MD 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗔 Removal from State Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2010 Rockville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvc. W., Silver Spring, MD 2090: 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Metastatic ancreatic cauentially list conditions. Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ed by the attending physician and detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown certificate has been signed by i rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 No director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 2 No ည 1 🗂 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 24 hours after death.
Funeral Director: After thi eted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending work? 1 ☐ Yes 2 ☐ No Natural Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00066515 M.D 2010 20 25

DHMH 17 Rev 7/2009

State

Registrar

10724 Little Patuxent Pkwy., Oclumbia, MD 20144

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year Rosalie Inez Barrett Medical 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Golden Living Center Westminster Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Min (Month, Day, Year) Director 410-26-6491 91 11/6/1919 MD Usual Residence of Decedent or 28a-f show be notified at 10a. State within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Carroll MD New Windsor 1 Yes 2 KNo Page 1 and 2 should be filed within 72 nours and 2 should be filed within 72 nours and fired Hygiene. If them 12 is marked other than "natural", or item 23 a or thant: If item 27 is marked other than "natural", or items 23a or thant: If item 27 is marked other than "natural". 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2000 Old New Windsor Road 21776 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces þ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify: 3 ₩ Widowed 4 □ Divorced Completed white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ Assembly worker Black & Decker 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Watson G. Nash Laura Ensor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy E. Adams, sister 20228 Middletown Rd., Freeland, MD. 21053 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/24/10 Parkton, Md. Cedar Grove UM Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00741 Eline Funeral Home Semmer 934 S. Main Street, Hampstead, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Metastatic Breast Cancer Medical Due to (or as a consequence of Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine ohysician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of) Physician/Medical 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Year 4 Pregnant at time of death 9 Unknown signed by the at a be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 -No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica of Vital 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director, Be Hospital 2X No မူ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred Natural Accident Suicide injury 5 Pending Division Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State

DHMH 17 Rev 7/2009

Registrar

32. Registrar's Signature

30. Name and address of person who completed cause of ceath (Item 23a),(Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month NOV. 25,2010 2:15 P.M. MAGDALENE COOPER BENNS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death COLUMBIA 4c. County of Death **Examiner** MY HOME ASSISTED 6359 RISING MOON LIVING HOWARD If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🛛 F Months Days Hours JULY 12, 1923 VIRGINIA 219-22-4033 87 **Director** Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland ural", or items 23a or 28a-f sho Examiner must be notified at Director MARYLAND SAINT LEONARD 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 335 MADELINE DRIVE 20685 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: BLACK Completed 3 X Widowed 4 Divorced event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) NONE HOUSE KEPPER 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Loof Health an Loof Health an Loof tem 27 is marn.
Traumatic events မ MAGDALENE WATERS LAWRENCE COOPER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 335 MADELINE DRIVE 20685 ST. LEONARD MARYLAND CONSTANCE EDWARDS (DAUGHTER Department of Health Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place)
SHILOH BAPT. CHURCH12/3/10 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State REEDVILLE VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licenses 22. Name and Address of Facility BERRY O. WADDY 5784 MARY BALL ROAD LANCASTER VIRGINIA 22503 isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lure. List only one cause on each ! e. Approximate Interval Between Onset and Death 23a. Part 1. Enter the a shock, or heart fa Immediate Cause (Fina Atheroscierotic Cardiovasular disease Physician/ disease or condition Medical resulting in death) Due to (r as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or illijury that initiated events Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No fo Month Day Year Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mellitus 1 Yes 2 No 3 Probably 4 Unknown Diahetes 24b. Were autopsy findings available prior to completion of cause of death? Dementia 24a. Was an performed? Yes 2 No 2 No 1 Yes after death.

Director: After this certific
in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 No MY HOME Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗆 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours af.

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

RB5

31. Date filed (Month, Day, Year) 32. Je

5857

yan. C.

Deale

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. legistrar's Signature B. Spark

serrance

Registrar

D.50653

Deale

SURAMA

GYAN - C-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Andrew	William	Brow
--------	---------	------

Andrew William Bro	1- For State Registrar	ate of Maryland /	Certificate		o ivientai m	_	g. No. 2011	39180	
Physician/	1. Decedent's Name (First, Midd					Date of Death Month December		3. Time of Death 0400 hrs	
Medical Examiner	Andrew	Andrew William a. Facility Name (if not institution, give street and number)		Brown Dec 4b. City, Town, or Location of Death			6, 2010 4c. County of Deat		
	Peninsula Regional Medical Center			Salisbury			Wicomico		
Funeral	5. Social Security Number	6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Yea		_	h(MM/DD/YYYY) 9. Bi Forei	ign	
Director	213-78-3519 1XM 2 F 43						-1967 Country)Maryland		
iny	Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town or Lo	cation			· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits	
bind show							1 X Yes 2 No		
ne Maryland or 28a-f show any fied at once.	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?								
th the 23a or notifie	34527 Pitts Avenue 11. Marital Status 12. Was Decedent Ever in U.			21850 S. 13. Was Decedent of Hispanic Origin? (Specify Yes or 1			USA	rican Indian, Black,	
r death with the Maryland or items 23s or 28s-f sh must be notified at one Funeral Director	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No			If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			White, etc.	ncan indian, black,	
after dans, or ner m	3 Widowed 4 Divorced If Yes, Give Year or Dates:			1 Yes 2 X No specify:			Specify: White		
5-0036 ed within 72 hours after fygiene. other than "astural" the Medical Examines Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12)		during	dent's Usual Occupa g most of working life			16b. Kind of Business	/Industry	
hin 72 than than than than than than than than	12	"	Manager			Survey Supplier			
MD 21215-0036 nd 2 should be filed within 7 lith and Mental Hygiene. m 27 is marked other than a mastic event, the Medical To Be Comple	17. Father's Name (First, Middle	Last)		Hamager	18.Mother's Name	(First, Middle, M		рршич	
d be fill tental I tental I tental I tental I barked event,	George 19a. Informant's Name/Relations	William	Brow 19h Ma		Patricia		ber, City or Town, Stat	Large	
AD 21 2 should 1 and Mer 27 is man To	Dixie Lee Brown			_			le, Marvla		
re, Ne l and l and Health	20a. Method of Disposition 1 Burial 2 X Cremation		20b. Place of Dis	position (Name of ce		Date	20c. Location - City o	r Town, State	
Pages nent of ant: I	4 Donation 5 Other S		•	, ,	arva 12-	-10-2010	Delmar. D	elaware	
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boun-						ounds Fu	ls Funeral Home		
Physician	23 Part I. Enter the dise se, or	mplications that caused the	ne death. Do not ente	705 E. Ma er the mode of dying	<u>in Street</u> , such as cardiac o	Salis r respiratory arre	bury Mary st, shock, or heart	Approximate Interval	
/Medical	failure. List only one caus in each line. Immediate Cause (Final disease or condition resulting in death) Between Onset: Death Due to (or as a consequence of):								
£xaminer.									
e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	quence of):					1	
cause. Enter Underlying Cause (Disease or injury that initiated									
cuted nd ransit	d.								
Records, P.O. Box 68760, The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be deached for use as the bunial - transit Completed by Physician/Medical Exi	□ AMENDED 23a,27 per me g912 2-4-11 vt								
8760 ificate ig phys is the b	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome 1 Live birth	e of pregnancy	Fetal death 3	Ectopic pregna	incy	23d. Date of deliver Month	ry Day Year	
Sox 6876 death certificate e attending phy I for use as the I	past 12 months? 4 Pregnant at time of death 5 Other (Specify)								
Division of Vital Records, P.O. Box 6876 ral or stending Physician: The law requires that the death certificat rs after death. *I Director: After this certificate has been signed by the attending phied in by the funeral director, page 2 should be detached for use as the errification: To Be Completed by Physician/IM	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?								
cords, P.O. B law requires that the d has been signed by the 2 should be detached npleted by Phy	1 Yes 2 No 3 Probably 4 ✔ Unknown								
Records, The law requires froate has been sig	24a. Was an 24b. Were autopsy prior to compl							utopsy findings available completion of cause of	
leco The law ate has	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No								
centific rector, p	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other:								
i of Vital Records ing Physician: The law required the fact this certificate has been uneral director, page 2 should not To Be Complete	1 Ves 2 No								
Division or spiral or Attending tours after death. meral Director: Aft filled in by the func Certification:	1 X Natural 5 Pen		ar)		Yes 2 No				
VISION ARTO PER ARTO		stigation 28e. Place of Inju	ıry - At home, farm, s	treet, factory, office	building, etc.	28f. Location (S or Town, St		ural Route Number, City	
ospital ospital hours a numeral I killed	4 Homicide determined (Specify)								
A Fu Fu	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
To the within To the comple	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)								
	(a(uu) 147 W) O.C.M.E. December 7, 2010						010		
	30. Name and address of person who completed cause of death (I)em 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
State		Assistant Medical Exa		all	uniore, MD 21				
Registra		2010 Beneva	p. 19"						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		Mental Hygi	ene	20101
_			Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	Re 2. Date of Death	g. No.	00101
	Physicia		Lam Chung		Month	Day Year 2010	3. Time of Death 5:10 p M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
			Holy Cross Hospital	Silver Spring	3	Montgon	nery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 2 2 0 - 2 1 - 1 5 2 3 1 M 2 F 8 4 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) Cou	hplace (State or Foreign Intry)
	Director		Usual Residence of Decedent		May 14	, 1925 T	/i´etnam
	and show	ō	10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	Maryl 28a-f otifie	rec	MD Montgomery Silve	r Spring			1 🗌 Yes 2 🏝 No
	h the	a D	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?
	ms 2;	Funeral Director	10713 Tenbrook Drive	20901	- 16 - N N -	Vietnam	
0	or ite		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ Narried	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Amer Black, White	
2	rs aftural",	Completed by		1 ☐ Yes 2 🕱 No Specify:		Specify: As	lan
<u>ဂ</u>	2 hou "natu edical	plet	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation kind of work done during most of work	ina 1	6b. Kind of Business	ndustry
121	thin 7 ane. than he Ma	mo.	Elementary/Seconday (0-12) College (1-4 or 5+) life. L	OO NOT use retired)			
Maryland 21215-0036	Hygik Other ent, t	Be (12 B 17. Father's Name (First, Middle, Last)	usiness Owner	ne (First, Middle, Ma	Retail	
<u>la</u>	l be fil lental rked tic ev	우	Can Chung	Lang 7		,	
ar	and Mand Is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Run	al Route Number, C	City or Town, State, Zip	Code)
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at			13 Tenbrook Dr.	., Silve	er Spring	,MD 20901
0			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposerer, creening and completely, creening and completely, creening and completely, creening and completely and creening and completely	matory or other place) N c	Date 29 2	20c. Location - City or	· ·
galtimore,	ant in			erer A	2010	Adelphi,	
勒	permit. Departri Importa any inju		1 1 1 1 1 t	፞ዯዄ፞፞፞፞፞፞፞፞፞፞፞ዯፙ፞፞፞፞፞፞፞፞፞፞፞፞፞፞፞ዿኯጜፙቔ 00 University I			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en				Approximate
1	Physician/		shock, or heart failure. List only one cause on each line. Immrediate Cause (Final disease or condition Aspiration P	neumonia			Interval Between Onset and Death WKS.
	Medical Examiner		resulting in death) a. Due to (or as a consequence of):				
		10	Sequentially list conditions, b. Renal Failur	e			days
	ped isit	min	if any, leading to immediate Cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Parkinson's	Disease			mos.
	be executed sician and burial-transi	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):	DIBEASE			ittos.
2	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical	dDementia		1		yrs.
22	certificat nding ph use as th	Mec	IF FEMALE:			1	
×	th cer ttendi or use	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of del Month	ivery Day Year
Box	the atter	ıysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 9 Unknown	Other (specify)		WOILI	Day Teal
J.	that the ned by the detach	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
	requires t been sign should be	q pa			1 🗆 Yes	s 2 M≥No 3 □ Pr	obably 4 🗆 Unknown
Vital Records,	law req has bee e 2 shou	plet			24a. Was an		opsy findings available completion of cause of
ě	hysician; The law r his certificate has b I director, page 2 sl	Completed			autopsy perform 1 Yes 2	ed? death?	2 X No
ta	cian; sertific setor,	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec.	k only one)		
<u>-</u>	Physi this c	2	1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time of	/		nce 6 Other (Speci	fy)
Division of	nding tth. : After s fune	Certificate:	1 Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 Yes 2 No	28d. Describe how	Injury occurred	
SIC	Atter er dea ector by the	ərtifi	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st	reet, factory, office		eet and Number or Rui	al Route Number,
2	tal or irs aft al Dir led in		building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate I completed filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or inve	occured at the time, date and place, ar stigation, in my opinion, death occurred a	nd due to the cause t the time, date and	e(s) and manner as sta place, and due to the o	ted. :ause(s) and manner stated.
	othe ithin 2 othe omple	M	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	death occurred at the time, date and place 29c. License number		ause(s) and manner as	
	7		Barbara Supanich, Rom, MD		29	11/24/3	
	V		30. Name and address of person who completed cause of death (Item 23a) (Type, Barbara Supanich, MD 1500 F	D 0065485		11/07/0	210
				orest Glen Road	d, Silve	er Spring	J, MD
	Stat Registra	e	31. Date filed (Month, Day, Year) 3. Registrar's Signature 3. Registrar	100			
	negistra	ı.	TO THE MAN POR PORTER	T - 1			

10-09034

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

(irk Joseph Chase	1- For State	State of Marylar		ment of F icate of D		I Mental Hy		g. No.	39182	
Physician/	Decedent's Name (First	t, Middle,Last)					2. Date of Death	nav Year	3. Time of Death 1630 hrs	
Medical Examiner	114		nase	Lab	City Town or I	ocation of Death	November	24, 2010 4c. County of De		
	5600 blk of Mont	nstitution, give street and num tgomery Road	ibei /		Elkridge	oution of Boats		Howard		
Funeral	5. Social Security Number	r 6. Sex 7	. Age (în yrs. last i		f Under 1 Year	If Under 24Hrs	_	h(MM/DD/YYYY) 9.	Birthplace (State or Foreign Country)	
Director	219-90-9502	1XM 2 F	46	Yrs.	Months Days	Hours Min.	Jan 11	, 1964	MD	
Á	Usual Residence of Dece	dent	10c. City. Tox	wn or Location					10d. Inside City Limits	
d St.		Howard		licott	Citv				1 Yes 2 No	
Aaryland 28a-f show 1 af once. ector	10e. Street and Number				Of, Zip Code		10	g. Citizen of What (Country?	
the M sa or 2 Direct	5616	Montgomery Rd		21043					ISA	
r death with the Maryland or items 23s or 28s-f sh must be notified at once Funeral Director	11. Marital Status 1 Never Married 2	12. Was Dece Armed For				oanic Origin? (Sp Mexican, Puerto		14. Race - Ar White, et	merican Indian, Black, c.	
er dea		1 Yes Divorced If Yes, Give Year	2 No	1 Ye	es XX No	specify:	specify: White			
ours after after a strain a series de by	45 Decedent's Education	on (Specify only highest grade	completed) 16			on (Give kind of v DO NOT use reti		16b. Kind of Busine	ess/Industry	
5-0036 led within 72 hour tygiene. the Medical Exar Completed	Elementary/Secondary	(0-12) College (1-	4 or 5+)	•	one	DO 1101 abo 101	.00)	none		
-003 I withi I withi I withi I withi I withi	17. Father's Name (First,	Middle, Last)				8.Mother's Name	(First, Middle, M	laiden Surname)		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica FO Be Comple	Vernon E.						es R. Wa			
D 21 should and Me 7 is ma	19a. Informant's Name/Re Vernon E. C							ber, Cify or Town, S City, MD	tate, Zip Code) 21043	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyggien. Important: If item 27 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	20a. Method of Disposition	on	20b. Plac		n (Name of cen		Date	20c. Location - Cif	y or Town, State	
Baltimore, permit. Pages 1 ar Department of Hei Important: If ite	1 Burial 2 Cr		Mew (Cathedr	al Ceme				e, Maryland	
Calting Calting Calumit.	21. Signature of Funeral	Service Licensee							uily FH, Inc.	
	23a Part I Enter the dise	ease, or complications that car	used the death. Do						ty, MD 21043 Approximate Interval	
Physician Wedical	failure. List only one	e cause on each line.							Between Onset and Death	
Examiner	Immediate Cause (Final or condition resulting in o	Due to (or as a	consequence of):							
<u></u>	Sequentially list condition if any, leading to immedia		consequence of):						+	
ted	cause. Enter Underlying	Cause c.								
d ansit	events resulting in death	d.	consequence of):							
60, te be executed ysician and burial - transit	UNPENDED	AMENDED						Name and the same		
760, ficate be g physici the buri	IF FEMALE: 23b. Was decedent pregn		utcome of pregnar		death 3 [Ectopic pregna	ancv	23d. Date of del Month	ivery Day Year	
box 6876. The death certificate the attending phy the attending phy ched for use as the Physician/M	past 12 months?	4 Pregna	ant at time of death		· (Specify)					
Bo. He deat the deat the deat the deformal hed for hed for hys.	1 Yes 2 No 9	Unknown 9 Unknown t conditions contributing to		ulting in the uno	erlying cause o	iven in Part I	23e. Did to	bacco use contribut	e to the cause of death?	
Division of Vital Records, P.O. Box 68766 tall or Attending Physician: The law requires that the death certificate as after death. The Third of the finite ordificate has been signed by the attending phy lied in by the funeral director, page 2 should be detached for use as the bertification: To Be Completed by Physician/Me		t conditions contributing to	death but not resu	ining in the dric	criying oddoo g	TOTAL TAREA	1 Yes	2 ✓ No 3	Probably 4 Unknown	
Records, The law requires fricate has been sig page 2 should be Completed							24a. Was a	ACCOUNT OF THE PARTY OF THE PAR	e autopsy findings available to completion of cause of	
COL te law 1 te has t ge 2 sh								med? deat		
tal Recian: The certifical certifical Be Co						of Death (Check				
F Vita	1 ✓ Yes 2	NO L		R/Outpatient			• -	Residence 6 🗸 0	Other: Scene	
n of ding P h. After funer		28a. Date of FOUND:	Day,Year) F	Bb. Time of Inju OUND:	· I	ry at Work? ∕es 2 √ No	Subject four			
isio Atten er death rector by the ficati	2 Accident 3 Suicide 6	Investigation Nov 24,	2010 1 of Injury - At hom	621 hrs e, farm, street,	factory, office b	uilding, etc.			r Rural Route Number, City	
Division or spital or attending nours after death. neral Director: After filled in by the fune fulled or better filled or better filled or better fune.	ream				ontgomery Road,					
		ifying Physician: To the besi ical Examiner:On the basis of	t of my knowledge, of examination and	death occurre	d at the time, da n, in my opinion	ate and place, and , death occurred	d due to the caus at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)	
To the Ho within 24 To the Fu completel	29b. Signature and title	and manner st	ated.		29c. Licens			29d. Date signed		
Quet 2					O.C.M.E. November 25, 2010					
		of person who completed caus			eet Raltime	ore, MD 2120	1			
7	Ana Rubio MD.		strar's Signature							
	State 31. Date filed (Month, Day, Year) 32. Redistrar's Signature Registrar									

Amend I Cecil C rjw 12/	our	nty Health Dept. 1- Forate 2010 Registrar	Type or Prir State of Ma	aryland	/ Departm	nent o	Health and of Death	Mental Hyg	jiene		39183
Physic /Med	ian	1. Decedent's Name (First, Middle, Las	ARLES COOK					2. Date of Dea Month 11		2010	3. Time of Death 4:00 A
Exami Funeral Director	ner	213 32 0003	HOSPITAL	e (In yrs. Iasi 75	birthday) If U	-		RACE 8. Date of Birth	I	HARFOR 9. Birth Coul MAR	D place (State or Fore ntry) YLAND
/anyland	o.	Usual Residence of Decedent 10a. State 10b. County MARYLAND HAI	RFORD	10c. City, T	own or Location		RE DE GRAC	т <u>. </u>			10d. Inside City Limi
with the has or 28s-	Director	10e. Street and Number 515 WARREN STE		২	10	f. Zip Coo				of What Cou	ntry?
and 21215-0036 be filed within 72 hours after death with the Maryland stal hygiane. be other than "naturel", or items 23a or 28s-f ehow event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:	Ever in U.S.		Decedent specify (of Hispanic Origin? (S Juban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. F	ED STATE Race - Americ Black, White, beity: BLA	can Indian, etc.
21215-0036 d within 72 hours aft glane. er than "naturel; or than Medical Exem	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation	1	life. DO N	of work do OT use re	ne during most of wo	rking		f Business/In	
N post	Be	12 17. Father's Name (First, Middle, Last) THEODORE COOK			COSTOL	י דעדו		me (First, Middle,		BLIC SO	
re, Maryla s 1 and 2 should I Health and Men item 27 is marks other traumatic	J.	19a. Informant's Name/Relationship (Type, Print)				eet and Number or Ri WAY, HAVR	ural Route Numbe			
Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any hightry or other traumatic event page.		20a. Method of Disposition 1 Strain 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen	1)	cem	22. Nan LI	or other NITE ne and Ac SA SO	place) D CEM 11/ Idress of Facility COTT FUNER WIS STREET	29/10 AL HOME.	HAVE		GRACE, MI
Physician /Medical Examiner	er	23a. Part1. Enter the disease, or companion shock, or heart failure. List only limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	one cause on each III	CREA a consequer	Do not enter the	mode of	dying, such as cardia	c or respiratory arr	est,		Approximate Interval Between Onset and Death
8760, cate be executed bhysicien and the burial-transit	dicai Examin	Cause Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequer	nce of):						
OT VITAL HECORDS, P.O. BOX 58/50. Physician: The law requires that the death certificate be this certificate has been signed by the attending physicie ral director, page 2 should be detached for use as the bur	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	ath 3 Ecto	pic pregna er (specify			23d.	Date of deliving Month	ery Day Year
Cords, P w requires that been signed b should be deta	ed by PI	Part II. Other significant conditions of	_	ut not resultin		ring cause	given in Part I.				he cause of death
f Vital Records, P.O. Box 6876 yelcien: The law requires that the death certificate by scentificate hes been signed by the ettending physici director, page 2 should be detached for use as the bu	Complet							24a. Was a autop: perfor	sy med?	prior to co death?	opsy findings availampletion of cause
Vita siciar certif irecto	Be	25. Was case referred to medical examiner?	Hospital:			7	Ott	ath Check only or			
Ing ling After	tion: To	1 ☐ Yes 2 € No 27. Manner of Leath 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ry 28	VOutpatient 3[Bb. Time of Injury	28c. I	4 ☐ Nursing I njury at Nork? I ☐ Yes 2 ☐ No	dome 5 Resid			(y)
Division of To the Hospital or Attending Ph within 24 hours effer death. To the Funarel Director: Atter th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj	ury - At home c. (Specify)	e, farm, street, fa	actory, off	Се	28f. Location (S City or Tow	treet and Nu n, State)	ımber or Rur	al Route Number,
he Hospil n 24 hour he Funare pietely fille	Medicai (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis o and manner st	f examination	edge, death occi n and/or investig	urred at the	e time, date and plac- ny opinion, death occ	e, and due to the curred at the time, c	ause(s) and late and place	manner as s ce, and due t	stated. o the cause(s)
To t To tl	Ž	29b. Signature and title of certifier	in M	D			ense number			gned (Month,	*
3+IVA		30. Name and address of person who SURESH DHANT.	4	leath (Item 2:	3a) (Type, Print)		15 3 44 F, HAYRE		1:17		- 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:36 AM 2010 John Lewis Cheadle Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ceci1 North East 720 Irishtown Road 9. Birthplace (State or Foreign Cou**Morth East** Maryland If Under 1 Year If Under 24 Hrs. Funeral Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Date of E. (Month, Day, 11 v 27 1 M 2 🗆 F Director 192-22-0793 84 July Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Cecil North East 10e. Street and Number 10g. Citizen of What Country? Funeral 21901 United States 720 Irishtown Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, GiveNational Year or DatesGuard Completed by Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 😾 Widowed 4 🗆 Divorced 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Grocery <u>Assistant Manager</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Cheadle Ada George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 638 Irishtown Road, North East, Maryland 21901 Ann L. Whitt / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November North East Methodist Church Cemetery Burial 2 Cremation 3 Removal from State 29,2010 4 ☐ Donation 5 ☐ Other (Specify) North East Maryland 21. Signature of Funeral Septor Ligan 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 t ins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a, Part 1, Enter the disease, or complice Approximate Interval Between shock, or heart failure. List only one Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be a in 24 hours after death. After this certificate has been signed by the attending physicia the Funeral Director: After this certificate has been signed by the attending physicia inpleted filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 F FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but of resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 200 No 1 ☐ Yes 2 € No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 (A) Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🕱 Natural work? 5 Pending 2 🗆 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Cerkitying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 30. Name and address of pers / who completed ause of death (Item 23a) (Type, Print) MAIN STREET ELKTON, MD R John Mulver 104

State Registrar 32. Registrar's Signature

10-09049 Kenneth R. Cox Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 Kenneth R. Cox 1- For State 1 1 _ 30 _ 10 Registrar Amen 0#20 b 20 c Peri 1. Decedent's Name (First, Middle, Last) Certificate of Death Rea. No 20c PerFHPCOer 2. Date of Death 3. Time of Death Physician/ Month Day November 25, 2010 0912 hrs Medical Examiner Kenneth Ray Cox Jr. 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Prince George's Hospital Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** D.C. Wash, Min Months Davs Hours 9-28-1984 26 Director 215-27-6001 1 XM 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 Yes 2 XNo P.G. Upper Marlboro MD show Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12442 Old Colony Dr. 20772 U.S.A. þ 14. Race - American Indian, Black, 13 Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes Black f Yes, Give Year or Dates: 1 Yes 2 X No specify: 3 Widowed 4 Divorced ≥ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Laborer Private of Health and Mental Hygiene.

1: If item 27 is marked other than other traumatic event, the Medical Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kenneth Ray Cox Sr. Wanda Stokes Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 19a. Informant's Name/Relationship (Type, Print) ဥ 12442 Old Colony Dr. Upper Marlboro Wanda Cox (Mother) 20c. Location - City or Town, State Brentwood, Laurel MD 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place)
ort Lincoln
D National 1 X Burial 2 Cremation 3 Removal from State 12-1-2010 permit. Pages
Department o
Important: Cem 4 Donation 5 Other Specify 21. Signature of Funeral Service License 22. Name and Address of Facility ^{22. Name and Address of Facility} Hunt Funeral Home 908 Kennedy St. N.W. Washington, D.C. trancy 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line We die al Death a. Complications of Gunshot Wound (s) Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Couse (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - trans sician/Medical UNPENDED AMENDED The law requires that the death certificate be Box 68760, 23d Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown certificate has been signed by the attrector, page 2 should be detached for 9 Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 V No 3 Probably 4 Unknown ੬ Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical Other Nursing Home 5 Residence 6 Other Hospital: 1 ✔ Inpatient 2 ER/Outpatient 3 DOA this 1 V Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury 28b. Time of Injury After 27. Manner of Death Subject shot Certification: Nov 10, 2009 1930 hrs 1 Natural 1 Yes 2 V No 5 Pending Director: d in by the f death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) Brooks Drive , Suitland , MD To the Hospital o within 24 hours af To the Funeral D determined (Specify) Multi-Family Apt. 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. November 26, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 32. Registr ir's Sign ture 31. Date filed (Month, Day Yes NOV 3 0 2010 State Registrar

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JR. CARROLL MAURICE 11:30 A ALBERT 2010 NOVEMBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY BETHESDA SUBURBAN HOSPITAL If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months Hours (Month, Day, Year WASHINGTON, DC 70 Director 579-50-4550 1940 APRIL Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f sho dical Examiner must be notified at filed within 72 hours after death with the Maryland Director 1X Yes 2 □ No GAITHERSBURG MONTGOMERY 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 20878 104 SHARPSTEAD LANE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Was Decedent Ever in 5.5.

Armed Forces?

If Yes, specify Cuban, Mexican

If Yes, Give

If Yes, Specify Cuban, Mexican

If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 BLACK 3 X Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natur ury or other traumatic event, the Medical.] 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MECHANIC GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLA-MAE FOWLER ALBERT M CARROLL SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14607 BRANDY HEIGHTS ROAD BRANDYWINE, MARYLAND 20613 AUNDRIA BRANCH/DGT. permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) XBurial 2 ☐ Cremation 3 ☐ Removal from State MD VETERANS CEMETERY 12/9/2010 CHELTENHAM, MARYLAND 4 ☐ Denation 5 ☐ Other (Specify) grature of Funeral S 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. price Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Ent. the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical ision of Vital Records, P.O. Box 6876 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 1 🗆 Yes 2 🖙 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 2 1 Tes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier. Bong uns 00057124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 MOLECULAR DRIVE # 206 ROCKVILLE, MARYLAND 20850 TRUONG BAO M.D. 31. Date filed (Month, Day, Year) NOV 3 0 2010 32. Registra s Signat State Registrar

CIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Leon Cohen 2010 11:00am November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Sunrise Assisted Living of Rockville Rockville 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth Funeral 1 🛛 M 2 🗆 F ^{(M}01th: P2^y0^Y1²¹925 Director 089-18-7348 Usual Residence of Decedent or 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Silver Spring Maryland Montaomeru 10e, Street and Number 10a, Citizen of What Country? Funeral items 23a 20904 U.S.A. 12705 Theresa Drive within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No 1943 ō ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give "natural", 1946 Caucasian 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Electrical Engineer Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ permit. Page 1 and 2 should be Department of Health and Ments. Important: If item 27 is marked any injury or other. Lena Braun Morris Cohen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pnint) 12705 Theresa Dr., Silver Spring, Maryland 20904 Adele H. Cohen - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 11/28/2010 Olney, Maryland 4 Donation 5 Other (Specify) Judean Mem. Gardens 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Lies 1800 New Hampshire Ave., Silver Spring, MD 20904 (dla 23a. Part 1. Enter the disease of shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Other (specify) g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 🗓 To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s 25. Was case referred to medica 26. Place of Death (Check only one) Be Assister 2 A No 1 Inpatient 2 ER/Outpatient 3 DOA 잍 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 X Natural 5 Pending 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a MD) 6+1 November 26. D63196 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 Irving St. NW. Washington, DC 20010 Matthew C. McAndrew. M.D., 31. Date filed (Month, Day, Year) State NOV 2 9 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ NOV. HELEN 22 2010 4:58 P M RUTH CLAYTON Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY 5. Social Security Number 8. Date of Birth (Month, Day, Year) APRIL 14, If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Min 1 🗆 M 2 💢 F Country)
ILLINOIS **Director** Yrs 1922 323-22-0947 88 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director tx☐ Yes 2 ☐ No MD. MONTGOMERY ROCKVILLE 10e. Street and Number 10a. Citizen of What Country? Funeral 4110 HEATHFIELD RD. U.S.A. 20853 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No 1 ☐ Yes 2X No Specify 3 ☐ Widowed 4X Divorced Specify: WWII Completed WHITE Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ PROFESSIONAL SINGER ENTERTAINMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ J. PAUL CLAYTON ELECTA HELEN BURBANK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARPITA H. CLAYTON/DAUGHTER 2301 GLENALLEN AVE., SILVER SPRING, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) COLESVILLE CEM. 11-29-201d ASSOC. COLESVILLE, 21. Signature of Funeral Service Liechsee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE.. RIVERDALE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SEPTIC SHOCK Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of. attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed ATRIAL FIBRILLATION that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 2 X No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 V Unknown been : 24b. Were autopsy findings available prior to completion of cause of 24a. Was an after death.

I Director: After this certificate has I on the funeral director, page 2 (performed: autopsy death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \(\square\) Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. pleted filled in by 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2 29d, Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

1500

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

2. Registrar's Sig

KHAN

NABILA

DR. 31. Date filed (Month. Date D65305

FOREST GLEN RD., SILVER SPRING, MD. 20910

NOV. 23, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ye ar 5:00 p M Louis T. Chanakas 2010 Nov. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Montgomery **Examiner** 2426 Dennis Avenue Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, 1 🕱 M 2 🗆 F Months Days Year) 1932 577-44-7543 78 Director Feb. Greece Usual Residence of Decedent 28a-f show 10b. County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Directo 1 ☐ Yes 2 🖺 No MD Silver Spring Montgomery ò 10e. Street and Number 10g. Citizen of What Country? 20902 items 23a Funeral 2426 Dennis Avenue 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, c. White 1 Never Married 2 Married White, etc. "natural", or þ 21215-0036 1 ☐ Yes 2 A No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) and 2 should be filed within Health and Mental Hygiene. Culinary Service Restauranteur Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vayia Harsoula Thomas Charakas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2426 Dennis Avenue, Silver Spring, MD 20902 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Helen Chanakas/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Gate of Heaven Cemetery 1 KBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Silver Spring, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Eacility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused shock, or heart failure. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Liver Metastases disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Cancer of Unknown Primary 1 year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and shed for use as the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year ned by the a edetached f 1 Yes 2 L 9 Unknown 9 Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by s been signe should be a Records, 1 \square Yes 2 $\raisebox{-4pt}{$\raisebox[-1.5ex]{}\raisebox{$\raisebox[-1.5ex]{$\raisebox[-1.5ex]{$\raisebox[-1.5ex]{$\raisebox[-1.5ex]{$\raisebox[-1.5ex]{$\raisebox[-1.5ex]{$\raisebox[-1.5ex]{$\raisebox[-1.5ex]{$\raisebox[-1.5ex]{$\raisebox[-1.5ex]{$\raisebox[-1.5ex]{$\raisebox[-1.5ex]{$\raisebox[-1.5ex]{$\raisebox[-1.5ex]{$\raisebox[-1.5ex]{$\raisebox[-1.5ex]{$\raisebox[-1.5ex]{$\raisebox[-1.5ex]{\raisebox{$\raisebox[-1.5ex]{}\raisebox{$\raisebox[-1.5ex]{}\raisebox{$\raisebox[-1.5ex]{\raisebox{$\raisebox[-1.5ex]{$\raisebox]}{\raisebox{$\raisebox[-1.5ex]{$\raisebox[-1.5ex]{$\raisebox[-1.5ex]{$\raisebox[-1.5ex]{$\raisebox[-1.5ex]{$\raisebox[-1.5ex]{$\raisebox[-1.5ex]{$\raisebox]}{\raisebox{$\raisebox[-1.5ex]{$\raisebox]}{\raisebox{$\raisebox[-1.5ex]{$\raisebox]}{\raisebox]}{\raisebox$ 24b. Were autopsy findings available prior to completion of cause of death? page 2 s performed' 1 Yes 2 No Yes 2X No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 X No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 I this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. Natural 5 Pending 1 🗌 Yes 2 No ☐ Accident ☐ Suicide Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) November 27,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Peter Sherer, MD 3921 Ferrara Drive, Wheaton, MD 20906 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Harry Coleman James Medical Nov 6:40n4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster <u>Carr</u>oll Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs **Funeral** 1**火** M 2 □ F Hours Director <u>212-36-5110</u> 1940 Jan 27, Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD Carroll Hampstead 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2084 Triple Green 21074 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 🗌 Widowed 4 🗎 Divorced Specify: white Year or Dates pernit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) accountant C. J. Miller Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harry Coleman Gertrude (Stahlin) Scharmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary M. Coleman, wife 2084 Triple Green Court, Hampstead, Md. 21074 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Carroll Cremation 11/22/2010 Hampstead, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home 934 S. Main Street, Hampstead, Md. 21074 remme 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying law requires that the death certificate be executed Cause (Disease or linjury that initiated events sician and burial-trans resulting in death) Last physician the burial Physician/Medical attending pl IE FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year ed by the a 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown Records, 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an nas 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes မ Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Accident within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fun 1 ☐ Yes 2 ☐ No. Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number D64408 29b. Signature and title of certific 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ajay Behari, M.D. 200 Memorial Avenue Westminster, Maryland 21157

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

68760

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 77, 2010 Paul Carlos Cofiell 9:47 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford County Sunshine Acres White Hall Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea 1 🗐 M 2 🗆 F Months Days Hours Director 216-16-3738 89 1920 Maryland 8 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits Reisterstown Maryland Baltimore County 1 🗆 Yes 2x No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21136 United States 3000 Black Rock Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Ves 2 No 1945—
If Yes, Give Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white 3 Wildowed 4 Divorced 1946 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) manufacturer machinist 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Huber Reynolds Cofiell Mary Adela Brooks permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Chenoweth - nephew 1918 Gibson Road White Hall, Maryland 21161 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Nov. 42 2010 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 22, Finksburg, Maryland Evergreen Mem. Gdns. Signature of Funeral Service Licens 22. Name and Address of Facility 22. Name and Address of Facility Eline FUneral Home 934 South Main Street Hampstead, Maryland 21074 M01072 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause of each line Immediate Cause (Final MANNEY Onset and Death Physician/ disease or condition resulting in death) OVER ZHOWA Medical Due to (or as a consequence of) Examiner SPIR TVOR 2 HONTE Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the aftending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be ASSISTED LIVING Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ No Hospital: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation Director; 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined 24 hours a Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29c. License number

DØD/6389 29d. Date signed (Month, Day, Year)

MOVEMBER 19, 2010 MAGTI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1716 HARPORD RESULIOS FALLSTONHONONO PENPECTO C VALARAO M.O.

State Registrar 31. Date filed (Month, Day, Year)

acks

. Registrar's Signature

			For State Registrar	State of	Marylar		artment rtificate			lental Hy	giene Reg. No.		39193
			Decedent's Name (First, Midd	le, Last)						2. Date of De			3. Time of Death
	Physici /Medio		Marsha A. Crai	a					N	ovembe	25 p.		2:30 A M
100	/wedic		4a. Facility Name (If not institution		per)		4b. City, To	wn, or Locat	tion of Death	O V CITIOC	1	County of Deat	
A.			Ft. Washington	Medical Cer	nter		Ft. Washington Prince Georges						rnes
	Funeral		5. Social Security Number	6. Sex 7.		last birthday)	If Under 1	Year If Ur	nder 24 Hrs.	8. Date of Bir (Month, D	rth	9. Birt	hplace (State or Foreign untry)
	Director		215-46-8293	1□M 2 X JF	62	Yrs.	Months [Days Hou				1948 M	
	p.		Usual Residence of Decedent								,		
	show	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
	Ba-f s	cto	Maryland Princ	e Georges	Ac	cokeek							1 X XYes 2 □ No
	ours after death with the Marylan ral", or items 23a or 28a-f show Examir or must be redified at	Funeral Director	10e. Street and Number				10f. Zip C	ode			10g. Citi	zen of What Co	untry?
	1th w 23a	<u>ra</u>	14305 Indian He	ad Highway			1	20607			l	JSA	
	r deg	nue	11. Marital Status	12. Was Decede Armed Force	es?	.S. 13.	Was Deceder	t of Hispanie Cuban, Me	ic Origin? (Spe xican, Puerto I	ecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White	
36	or if		1 Never Married 2 X Mar	If Yes Give	X X /10		1 □Yes 2 X		ecify:	, ,			hite
8	72 hours after death with the Maryland natural", or items 23a or 28a-f show Alcel Examinat hour culfied at	d by	3 Widowed 4 Divorced	Year or Date	es:								
5	72 h "natu	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)		16a. Dece	dent's Usual (kind of work	Occupation done during	most of working	ng	î .	nd of Business/	
121	/ithin	ш	Elementary/Secondary (0-12)	College (1-4	or 5+)			retired)			Prir	nce Geor	rges
2	lled v -lygie her t nt, th		12th. 17. Father's Name (First, Middle.	8+		<u>lea</u>	cher	10.10	Nother's Name	(Einst Middle		ol Syst	em
äng	be fi ntal l ad ot evel	B	, ,	Lasij						,		Surriame)	
Ĕ	2 should be filed within 72 hours after deal and Mental Hygiene. Is marked other than "natural", or items raumatic event, Ita Mozical Examination	ဥ	Stanley Craig			T			thryn				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, Its Miczical I once.		19a. Informant's Name/Relations			!	-					r Town, State, 2	•
e,	l and Healt		James M. Hopta/	nuspand	DOL F							ek, MD.	
ō	Pages nent of h		20a. Method of Disposition 1 □ Burial 2 🂢 Cremation	3 Removal from Sta	ate 200. F	cemetery, cre	sition (Name matory or othe	er place)	, ,	ate	20c. Lo	cation - City or	Town, State
Ë	ттел tant:		4 ☐ Donation 5 ☐ Other (5	Specify)	Atla	antic (Cremato	rv	Nov.	27. 201	LO G1	enn Ber	nie, MD.
3a	permit Depar Impor any In		21. Signature of Funeral Service	Licensee		2:	2. Name and	Address of F		ntt Fur			
-	<u> </u>		allent	6		130	035 Old	l Wash	ington	Rd. Wa	aldor	f. MD 2	0601
			23a. Part 1. Enter the disease, o shock, or heart failure. List	r complications that cau t only one cause on eac	sed the deat h line.	h. Do not en	ter the mode of	of dying, suc	ch as cardiac o	r respiratory a	arrest,	,	Approximate Interval Between
4	Physician	1	Immediate Cause (Final disease or condition	C	orono	ara	Arter	Di	sease			1	Onset and Death
	/Medical		resulting in death)	a.	as a conseq	-4	- (
	Examiner		Sequentially list conditions	b									
	₽ #	Examiner	Sequentially list conditions, cause. Enter Underlying	Due to (or	as a conse	uence of):							
	ecute nd trans	ami	Cause (Disease or injury that initiated events	с									
Ö,	cate be executed obysician and the burial-transit	m	resulting in death) Last	Due to (or	as a conseq	uence of):							
8760,	cate b	dical		d									
9	leath certifica attending ph I for use as th	Mec	IF FEMALE:										
Box	th ce tendi	an/I	23b. Was decedent pregnant	23c. If yes, outco	me of pregna th 2 \square Feta		☐ Ectopic pre	nancv			1 :	23d. Date of del	
0.	e des he at ed fo	Sici	in the past 12 months? 1 □ Yes 2 ☒ No		nt at time of d		Other (spec					Month	Day Year
P.0	at the I by t	Physician/Med	9 Unknown							1			
	sician; The law requires that the de certificate has been signed by the rector, page 2 should be detached	by I	Part II. Other significant conditi	ons contributing to deat	h but not res	ulting in the u	nderlying cau	se given in P	Part I.	23e. Did	tobacco u	ise contribute to	the cause of death?
Š	equir sen s ould	Completed by	- Agree Co	ension tal's Augi						1 🗆	Yes 2[□ No 3□ Pr	obably 4 Unknown
ပ္က	aw re as be 2 sho	plet	Prinzme	tal's Hugi	На					24a. Was		24b. Were au	topsy findings available
ď	The late has	E									psy ormed? 2 X No	death?	completion of cause of 2 □ No
ta	an;	Be C	25. Was case referred to medica	1				26 F	Place of Death	1 □Yes		I lightes	2 🗆 100
>	ysici is ce direc	0 0	examiner? 1 ☐ Yes 2 No	Hospital:	atient 2/X	ER/Outpatie	nt 3 🗆 DOA	Other				6 ☐ Other (Spe	cify)
0	g Ph erth eral	핕	27. Manner of Death	28a. Date of	Injury	28b. Time o		Injury at Work?		28d. Describe			Only)
<u>io</u>	ath. r; Aff	atio	1 Natural 5 ☐ Pendir 2 ☐ Accident investi		Ďay, Year)	Injury	M	vvoik? 1 ☐ Yes	2 🗆 No				
Division of Vital Records,	Atte	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern		Injury - At he	ome, farm, str	eet, factory, o	ffice	2				ıral Route Number,
Ö	al or s afte	ert	4 🗆 Homicide	building	, etc. (<i>Specii</i>	<i>y)</i>			- 1	City or To	wn, State)	
	spita hours mera y fille		29a. Certifier 1 Certifyi	ng Physician: To the be	est of my kno	wledge, deat	h occurred at	the time, da	ite and place,	and due to the	e cause(s)	and manner as	s stated.
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as t	Medical	(Check only 2 Medical one)	Examiner: On the bas and manner	r stated.	ation and/or in	vestigation, ir	my opinion	, death occurre	ed at the time	, date and	I place, and due	to the cause(s)
	To the Vithin To the COMP	M	29b. Signature and title of certific		//			icense numb			29d. Dat	te signed (Monti	h, Day, Year)
			1/	////	//	MD	1	7467	741		Nove	mber as	7,2010
	-4-7		30. Name and address of person	who completed cause	of death (Iten	n 23a) (Type	Print)						,
	2810		DEEPAK SACHI	2010 32. Feg	((7))	ILLIA C	CAGTE	20 7	FORT	WASHI	Gin	N MC	D 20744
	Sta	te	31. Date filed (Month, Day, Year)	32. Keg	istrar's Signa	iture			. 0 101	-~1111[, , , ,	- 00079
	Registr	_	NOV 3	U 2010 A	wa	p. 19	arke						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		-	For State		State of	Marylar		artmer <i>rtificat</i>			and M		_	001	1 00	1.01
			Registrar 1. Decedent's Name	(First, Middle, Las	st)		001	imoat	0 01 0	Cutii		2. Date of De		the state of	3. Time of	Death
	Physicia Medic		Robert Pa	aul Dempse	y							November November	· 23 ^{Da}	2010 Year	7:40 p	М
	Examin	er	4a. Facility Name (if I	not institution, give 7 Hospice- C		•			Town, or	Location	of Death			. County of Dea		
	Funeral		5. Social Security Nu	ımber 6. S	ex 7.	Age (In yrs. i	ast birthday)		rwood r 1 Year	If Under	24 Hrs.	8. Date of Birt		Montgomer	rthplace (State or	Foreign
	Director		578-40-811	LO 1	™ м 2 □ F		Yrs.	Months	Days	Hours	Min.	May 29,	1931	Was	hington,	DC DC
	show d at	Ē	Usual Residence of I	Decedent 10b. County		10c. Cit	ty, Town or Loc	cation							10d. Inside Cit	v Limite
	larylar 3a-f sh ified a	Funeral Director	Md	Frederic	ık.	100.0	New Market								1 \(\text{Yes}	
	the N a or 28	ă	10e. Street and Num					10f. Zi	o Code				10g. Ci	tizen of What Co	ountry?	
	h with	nera	7013 Fox	Chase Road					217	74			USA			
	r deat or iten niner r		11. Marital Status1 ☐ Never Marrie	od 2 Marriad	12. Was Decede Armed Force	s?	S. 13. V	Was Dece f Yes, spe	dent of His cify Cubar	spanic Ori n, Mexicar	gin? (Spe n, Puerto l	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit		
21215-0036	s afte ral", c Exarr	ed by	3 Widowed 4		1 X Yes 2 If Yes, Give Year or Dates		54	1 🗌 Yes	2 🕱 No	Specify:				Specify: Whit	e	
2-0	2 hour	plet	(Spec	15. Decedent's E cify only highest gr			16a. Deced	ecedent's Usual Occupation 3ive kind of work done during most of working								
121	thin 7 ene. • than he Me	Completed	Elementary/Seco	nday (0-12)	College (1-4	or 5+)	life. D	O NOT us	e retired)	Ü					D3 2 1	
d 2	iled w I Hygii other rent, t	å	17. Father's Name (F	First, Middle, Last)			1	Plumbe	<u>-</u>			(First, Middle,	Maiden	Surname)	Plumbin	9
ylan	d be f Menta arked atic ev	٩	Michael De	empsey						Mary	Carro	011				
Baltimore, Maryland	shoul and I		19a. Informant's Nar		,		T T	-						Town, State, Zi	ip Code)	
Deborah deSibour/Daughter 7013 Fox Chase Road, New Market, M 20a. Method of Disposition 20b. Place of Disposition (Name of Date							, MD 21774 20c. Location - City or Town, State									
mor	10a. State 10b. County 10c. City, Town or Location New Market 10a. Street and Number 10f. Zip Code 21774 10a. Street and Number 7013 Fox Chase Road 12. Was Decedent Ever in U.S. Armed Forces? 15. Decedent's Education 16a. Decedent's Usual Occupation						Dec. 2010	. 3,								
alti	2010 21. Signature of Funeral Service Licensee 22. Name and Address of Faility 23. Signature of Funeral Service Licensee															
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring								ng, MD 20	901							
			23a. Part 1. Enter the shock, or hear		plications that cau e cause on each	sed the deat line.	h. Do not ente	er the mod	le of dying	, such as	cardiac o	r respiratory arı	est,		Approximate Interval Betw	/een
	Physician/ Medical		Immediate Cause (F disease or condition resulting in death)		a. Demonti	as a consequ	uonas of								Onset and D	eaur
	Examiner				Due to (or	as a consequ	derice (ii).									
	_ 0 +	Examiner	Sequentially list con if any, leading to imi cause. Enter Underl	mediate	b. Due to (or	as a consequ	uence of):									
	and and transi	xam	Cause (Disease or ii that initiated events resulting in death) L	injury	C. Due to /or	as a consequ	uence of									
_	icate be executed physician and street transit sthe burial-transit		resulting in death) L	asi	Due to (or	as a consequ	derice oi).								-	
3760	ficate g phys	Nedical			d								_			
Box 68	ending r use a	an/N	IF FEMALE: 23b. Was decedent p		23c. If yes, outcom		ancy al death 3 □	Ectopic	pregnancy	,				23d. Date of de	elivery	ų,
80	death the att	Physician/M	in the past 12 m 1 ☐ Yes 2 ☐ g ☐ Unknown		4 ☐ Pregnar 9 ☐ Unknov	nt at time of		Other (s)						Month	Day Ye	ear
Ö.	at the ed by detach		Part II. Other signific	cant conditions	ontributing to deat	h but not res	sulting in the u	inderlying	cause give	en in Part	1.	23e. Did to	bacco u	use contribute to	the cause of de	ath?
S,	n sign	ed by	Pneumoni	a, COPD, A	sthma							1 🗆 '	Yes 2	□ No 3 □ F	robably 4 🔼	Inknown
Ö	w requires the second s	Completed										24a. Was			itopsy findings av	
Bec	sician: The law s certificate has t lirector, page 2 s	E G						·				autop perfo 1 \(\sum \) Yes	rmed?	death?	s 2 No	luse of
tal	cian: sertific ector,	Be	25. Was case referre examiner?	T	Hospital:				-	ce of Dea						
Ž	Physic rthis or	5: To	1 Yes 2 x 27. Manner of Death	MAO	1 lnp		ER/Outpatien 28b. Time of		Other	4 ∐ Nı		me 5 Resid		Other (Spec	pice	
Due to (or as a consequence of): Due to (or as a consequence of):																
Division of Vital Records, P.O.	r Atte ter dea rectol	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	e 28e. Place of	Injury - At ho etc. (Specif)		eet, factor	y, office		2	28f. Location (S City or Tow			ral Route Numbe	er,
ă	oital o										1					
	e Hosi 24 ho e Fune leted f	Medical		☐ Certifying Phys ☐ Medical Exami ☑ Certifying Nurs		of examination	n and/or invest	tigation, in	my opinior	n, death oc	curred at	the time, date a	nd place	, and due to the	cause(s) and man	ner stated.
	To the comp	2	29b. Signature and ti			per	, Allowiouge, C		. License		and place			te signed (Mont		
	13+1 1		1290	rak	mille	1. C.	RNP			R14	13201			124/10		
	(4)		30. Name and address Dekrah Mil	ss of person who c	ompleted cause of	f death (Item	1 23a) (Type, P	rint)	MD 2				/	7		
	Stat	e	31. Date filed (Month	, Day, Year)	32 R egi	strar's Signa	ture									
	Registra	•	Nf	OV 26 20	10	N.A.	A los	White !	4							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7645AM mes Medical 4c. County of Death Name (if not institution, give street and number) **Examiner** stim 0 If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day,
June 23 9. Birthplace (State or Foreign (In yrs. last birthday **Funeral** 1 🔀 M 2 🗆 F Country)
Mississippi Director 056-30-3067 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 🗆 Yes 2 屎 No NY St. Lawrence Rouverneur 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 68 West Main Street 13642 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces Black, White, etc þ 1 Never Married 2 Married X Yes 2 No African-Americah Maryland 21215-0036 1 Yes 2 X No Specify If Yes, Give Completed 3 Widowed 4 X Divorced Year or Dates.1954-58 Native American Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) State Government 5+ Social Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ပ Florence Lewis Dixon Moses 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a Richville, New York Box 94 Clara Dixon/ex-wife other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of F
Important: If ite
any injury or ott 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 11/26/2010 Woodbine, Maryland 21. Sig latere of Funeral Servi Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. CLarksville, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Pnysiciani disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Box 68760 for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the a Yes 2 No 1 Yes 2 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No las l After this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natura! 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie xamiqer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Checi Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only o ertifying 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print) Baulevard, Baltimore MD 2121 egistrar's Signature State Ensure Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 01:41 AM November Raymond Delbert Dull Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Cecil Union Hospital of Cecil County Elkton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Kallamazoo Michigan 6. Sex Funeral 1 XM 2 □ F Months Days Hours Min April 15,1947 63 Director 212-48-6476 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Maryland Cecil North East 10e. Street and Number 5 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 21901 United States 438 Red Toad Road within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or **A** 1 Yes 2 XNo Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working e 1 and 2 should be filed within 72 to thealth and Mental Hygiene.
If item 27 is marked other than "nor other traumatic event, the Medi life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Irene Mae Bowdish Claburn Louis Dull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 25 West Walnut Street, North East, Maryland21901 Kristi E. Dull / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 30, 2010 Newark, Delaware 4 Donation Maverdale Crematory 21. Signature Fun at le License 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ CIRMHOSIS OF LIVER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner FNLEPHALOPATHY Ite PATIC Sequentially list conditions il any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of, Exami ng physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 4 Pregnant signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred A.fter work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending n 24 hours are redeath e Funeral Director: Lift eleted filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours a er des

To the Funeral Director

completed filled i by th 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) 1-1. Nonge 10 11/29/10 02065733 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NARMANA RAO V. PULA , 126 A E. HIGH STAUL Mg 21921 ISLKTON, 31. Date filed (Month, Day, Year) 22. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

3 0 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 18:46 M **Physician** DOUGLASS 2010 DILORENZO MARIAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1072771941 Washington, DC 69 577-56-6235 Director Usual Residence of Decedent 10d, Inside City Limits 23a or 28a-f show t be notified at 10c. City, Town or Location 10a, State 10h County 1 ☐ Yes 2 ¥No Ft. Washington Directo Maryland Prince George's 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number USA 20744 must be 1201 Swan Harbour Circle Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 X Married White ō 1 ☐ Yes 2 🙀 No Specify: <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than Librarian Private School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F Be Schumm Elizabeth Helen Douglass Pau1 Varney ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau once. 1201 Swan Harbour Circle Ft. Washington, MD 20744 Henry DiLorenzo - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Nurial 2 Cremation 3 Removal from State 12/04/2010 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA . Ihh 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PULMONARY HYPERTENSION **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner SCLERO DE RMA Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Tetal death Month in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 2 No 1 TYes 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Natural 2 Acciden Injury 5 Pending 1 🗌 Yes 2 No investigation Accident 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

State Registrar

AGGARWAL 32. Registras s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RES-000

28,2010

November

600 North Wolfe St, Baltimore, MD, 21287

10-08978 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Martha Louise Dixon 1. For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3 Time of Death Physician/ Month Day November 23, 2010 0308 hrs Medical Examiner MARTHA LOUISE DIXON 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Montgomery 13901 Berryville Road Germantown 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. B. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Country) Months Davs Hours Director 578-44-0147 1 M 2K F 80 09/13/1930 MD Usual Residence of Decedent 10c. City, Town or Location or 28a-f show MD Montgomery Germantown with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13901 Berryville Road 20874 USA 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces's If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes Yes, Give Year Specify: Black 4 Divorced 1 X Yes 2 No specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hou
Department of Health and Mental Hygiene.
Important: If iten 27 is marked other than "natt
injury or other traumatic event, the Medical East during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Administrator City of New York 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Harry Clipper Ruby Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley C. Shields - niece 13901 Berryville Road, Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12/01/10 Germantown, MD Seheca Church Cem. 4 Dogation 5 Other Specify ture of Funeral Service Li 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 Part I. Enter the disease, or comp extions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on Between Onset and /Medical Death a, Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and

UNPENDED AMENDED IF FEMALE 23b. Was decedent pregnant in the Live birth past 12 months? Pregnant at time of death 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause give

_Lectopic pregnar	Cy	IVIOITA	Day	Tear
ven in Part I.	23e. Did toba	acco use co	entribute to the ca	ause of death
	1 Ves	2 No	3 Probably	4 Unkno

23d Date of delivery

26.Place of De 25. Was case referred to medical examiner? Inpatient 2 ER/Outpatient 3 DOA 1 V Yes

	performed? 1 Yes 2 No 1 Yes conly one) Ing Home 5 Residence 6 Other Scene		2 No		
ath (Check	only one)				
Nursir	ng Home	Res	sidence	6 🗸 Other: Scene	
/ork?	28d Desc	ribe how	iniury oc	curred	

28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 V Natural 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, 3 Suicide Could not be determined Homicide

1 Yes 2 No	
office building, etc.	28f. Location (Street and Number or Rural Route Number, or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

28b. Time of Injury

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD Assistant Medical Examiner

31. Date filed (Month, Day, Year) State Registrar

sician/Medical

Phy

Ś

Completed certificate has been rector, page 2 should

Be

Diabetes mellitus

the attending physician ed for use as the burial -

signed by the I be detached f

this

Director: d in by the f

Box 68760

Division of Vital Records, P.O.

32. Registrar's Signature

10d, Inside City Limits 1 Yes 2 No

14 Race - American Indian, Black,

23c. If yes, outcome of pregnancy

2 Fetal death 5 Other (Specify)

24b. Were autopsy findings available Was ar

prior to completion of cause of

28c. Injury at W

29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 23, 2010

111 Penn Street, Baltimore, MD 21201

Registrar

State

RB Stl

DHMH 17 Rev 1/2001

M.D. FORT WASHINGTON MEDICAL CENTER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

AMIR MIRZA-ALIKHANI,

NOV 3 U 2010

31. Date filed (Month, Day, Year)

11711 LIVINGSTON ROAD

MD 20744

FORT WASHINGTON,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month Year DESKINS UN 2:00 AM 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hearthelds 2+ Easton Easton Talbot 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign $V \hat{A}^{ountry)}$ 6. Sex 7. Age (In vrs. last birthday) 8 Date of Birth 1 □ M 2 □ F Months Days Min Hours 3 Month, Day Year 7 214-30-0699 93 Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits TALBOT EASTON 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 PORT STREET 21601 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 X No WHITE If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: Specify: 3 XWIdowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) I.R.S. Elementary/Seconday (0-12) College (1-4 or 5+) ANALYST U.S.GOVT. 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES WALTER SCOTT LOUISE MELVINE LOEFFLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RAYMOND DESKINS, JR. - SON 9561 MORNING MEWS CLOUMBIA, MD. 21046 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State MD. VETERANS CEM. 12-14-10 CHELTENHAM, MD. 4 Donation 5 ☐ Other (Specify) Signature of Juneral Service Licensee M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neart Sequentially list conditions Due to (or as consequence of)

Physician/ Medical Examiner

attending physician and for use as the burial-transit

been signed by the

has

after death.

Director: After this certificate I

within 24 hours a

npleted

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

10a State

MD.

Examiner

Funeral

Director

or 28a-f show

items 23a

ō

"natural",

al Hygiene.

permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie. Important: if item 27 is marked other 1 any injury or other traumatic event, th once.

must be notified at

the Medical Examiner

Director

Funeral

þ

Completed

Be

2

Examiner

Physician/Medical

þ

Certificate: To Be

Medical

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed

25. Was case referred to medical

29b. Signature and title of certifier

2 🗷 No

5 Pending

Investigation 6 Could not be

determined

examiner?

27. Manner of Death

Natural

4 Homicide

29a. Certifier

(Check

Accident Suicide

23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death

28a. Date of injury (Month, Day, Year)

Medical Examiner: On the basis of examination and/or investig 2 Medical Examiner: On the basis of examination showledge, do 3 Certifying Nurse Practioner: To the best of my knowledge, do

hbrillation

regurgitation

Due to (or as a consequence of):

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Li Fetal acc.
Pregnant at time of death
Unknown

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

tension

perlipidemia

cardiomu

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death? 2 M No 3 Probably 4 D Unknown

1 🗆 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

	1 🗆 Yes 2 🗆	No 1 Tyes	2 🗌 No
6. Place of Death (Chec	ck only one)		
Other: 4 Nursing H	ome 5 Residence	6 Other (Specifi) assisked living
	28d. Describe how inju		_

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town. State) Certifying Physician: To the best of my knowledge, death occ

29c Licer	ase number	29d Date signed (Month	Day Voorl							
eath occurred at	th occurred at the time, date and place, and due to the cause(s) and manner as stated.									
ation, in my opi	nion, death occurred at the time, date	e and place, and due to the ca	ause(s) and manner state							
culculat the till	ne, date and place, and due to the t	vause(s) and manner as stati	ea.							

D0059939

26. Place of Death (

2 🗌 No

28c. Injury at

work 1 🗌 Yes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21601 River Physicians 508 Idlewild Elliot, MD Miles 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nov. 21, 2010 Sharon L. Filomena 9:50 p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 12, 1941 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 X F D.C. Director 216-40-7012 Yrs Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No MD P.G. Bowie 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 14939 Nashua Lane 20716 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White "natural" 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Airforce Sergeant's Elementary/Seconday (0-12) College (1-4 or 5+) 12 Receptionist Association Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Wilbur C. Cheek Lillian Landis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela C. Filomena-Barton/Daughter 5945 Sandy Ridge Court, Elkridge, MD 21075 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. 29 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 2010 Brentwood, MD Signature of Funeral Service 22. Name and Address of Facility
Francis J. Collins Fuberal Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the diseas complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 Li retail ass...
Pregnant at time of death in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s after death.

Director: After this certificate has autopsy performed? Yes 2 No death? 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Hatural Accident 5 Pending 1 Tes 2 No Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined OTo the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title

30. Name and address of person who complete

no

ause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Monti Medical Facility Name (if not institution, give street and number) **Examiner** or Location of Death 4c. County of Death TIMOV If Under 6. Sex 1 **M** M 2 □ F 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 8, **Funeral** 9. Birthplace (State or Foreign Months Hours Min. Day, Year) 1940 217-36-9653 70 **Director** Yrs. Maryland Usual Residence of Decedent 28a-f show 10b, County 10a. State with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Carroll Hampstead 1 Tes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3520 Hampstead-Mexico Road 21074 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces'
1 Yes 2 [
If Yes, Give Black, White, etc. "natural", or ģ 1 Never Married 2 Married 2 □ No 1961-Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 1964 Completed white Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any injury or other traumatic event, the Mentage. 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Parts Distributor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Andrew C. Fisher II Mary E. Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen K. Fisher, wife 3520 Hampstead-Mexico Rd, Hampstead, MD 21074 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadow Branch Cem 11/24/2010 Westminster, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Part]. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each lin Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consulu-Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director; After this certificate has ! autopsy performed? 2 No Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only ne) examiner? Hospital Other: 욘 1 Tes 2 [2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of Certificate: 28b. Time of iniury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check The dical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and title of ce 29d. Date signed (Month, Day, Year) DOOS2367 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) breene Street Baltimore, MD 21201

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / Department / Departmen	artment of Health and rtificate of Death	, ,	ene .No. 200 U.S
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year 3. Time of Death
J.,	/Medic Examir	cal	RONALD EUGENE FRAZIER 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	DECEMBE	R 5 2010 1:25P M 4c. County of Death
- And	LAGIIII	lei	4915 QUADE CIRCLE	WALDORF		CHARLES
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 212-66-4974 75. Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Y AUG • 22	9. Birthplace (State or Foreign Country) WASH., D.C.
	and ww		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	reation	1100.221	10d. Inside City Limits
	Maryli a-f sho	tor	MD CHARLES WALDON			1 ☐ Yes 2 No
	or 28%	Direc	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
	Jeath w	Funeral Director	4915 QUADE CIRCLE 11. Marital Status 12. Was Decedent Ever in U.S. 13. V	20602 Was Decedent of Hispanic Origin? (S	necify Yes or No-	U. S. A.
9800	within 72 hours after death with the Maryland liene. than "natural", or thems 23a or 28a-f show the Medical Eventine must be notified at	þ	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (S if Yes, specify Cuban, Mexican, Puert 1 □Yes 2 【★No Specify:	o Rican, etc.)	Black, White, etc. Specify: WHITE
21215-0036	be filed within 72 ho ntal Hygiene. id other than "natuu event, Im Modell	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king 161	b. Kind of Business/Industry
121	e filed withir al Hygiene. other than vent, the M		2 STORI	E MANAGER		URNITURE STORE
Maryland		To Be	17. Father's Name (First, Middle, Last) RAYFORD EUGENE FRAZIER		ne (First, Middle, Mai ELIZABE'	TH RHODES
l ary	and s m			ng Address (Street and Number or Ru	ıral Route Number, C	ity or Town, State, Zip Code)
	1 and 2 Health tem 27 i		20a. Method of Disposition 20b. Place of Dispo			MARYLAND 20602 c. Location - City or Town, State
<u>m</u>	00		1 ☐ Burial 2 ★ remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	natory or other place) DEC	EMBER	LEXANDRIA, VA
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee M00641 56	. Name and Address of Facility RA	YMOND FUI	NL. SERVICE, P.A. PLATA, MD 20646
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest	, Approximate Interval Between
ă	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	Cercce		Onset and Death
	Examiner		Due to (or as a consequence of):			
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
oʻ	rificate be executed ig physician and as the burial-transit	Ехаг	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
68760,	icate b physici the bu	edical	d		-	
		Physician/Me		Ectopic pregnancy		23d. Date of delivery Month Day Year
P.O.	that the de	hysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)		
rds, I	+ 0 C	þ	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		co use contribute to the cause of death?
Seco	ding Physician: The law requires After this certificate has been sign funeral director, page 2 should be	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
E E	in: The lificate or, pag		25. Was case referred to medical		performed 1 □Yes 2 □	death?
Ę Ś	hysicia his cer I direct	To Be	examiner? 1 Yes 2 No	Othori	th (Check only one) ome 5 Residence	e 6 □Other (Specify)
ouo	ding P h. After t funera	tion:	27. Manner of Death 1 → Natural 5 → Pending (Month, Day, Year) 2 → Akcident investigation	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how i	njury occurred
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p	Certification:	2 ☐ Acident investigation 3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, streething 28e. Place of Injury - At home, streething 28e. Place of I		28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	To the Hospital within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death 2. Medical Examiner: On the basis of examination and/or invand manner stated.	occurred at the time, date and place restigation, in my opinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			20 Name and olders of arms	102835	, 2	12/6/10
			30. Name and address of person who completed cause of death (Item 23a) (Type, F	3 Latla	te 1	120646
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOVEMBER 22, 2010 9:00P M THEODORE MCDONALD GARLIC /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FUTURECARE REHABILITATION CENTER BALTIMORE BALTIMORE Social Security Number 7. Age (In vrs. last birthday. If Under 1 Year _ If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1944 WASHINGTON, DC 578-56-6804 JULY 11, Director 66 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exerciper must be redified at Director 1X Yes 2 □ No PRINCE GEORGES CAPITOL HEIGHTS MD 10g. Citizen of What Country? 10e Street and Number 10f Zin Code UNITED STATES 20743 6615 SEAT PLEASANT DRIVE death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: BLACK Completed by Year or Dates: Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) MAINTENANCE WORKER MAINTENANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any jiny or other traumatic event once. Be ROBERT NAPOLEON GARLIC, SR. MARY ELIZABETH YANCEY GARLIC ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLORIA EASTER/SISTER 5314 DILL DRIVE, OXON HILL, MD 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State HERITAGE MEMORIAL CEM 11/27/2010 4 □ Donation 5 □ Other (Specify) WALDORF, MARYLAND 21. Signature of Funeral Service Licensee THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ON Cancer 6 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): executed burial-trar Due to (or as a consequence of): P.O. Box 68760. The law requires that the death certificate be Physician/Medical as IF FEMALE for use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) the detached 9 I Inknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 1 □ Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 4 Hospital or Attending Physician: Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one, Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this filled in by the funeral Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hintan 1132 Desau

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Frederick William Hawbaker Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington County Hospital Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth OCT 20, 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) Min 1**XX**M 2 □ I Year 921 County Maryland 219-05-2607 Director 89 Usual Residence of Decedent show filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2XXNo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17331 Ontario Drive 21740 USA 12. Was Decedent Ever in U.S.

Armed Forces?
144 Yes 2 | No 1942
If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc ģ 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: Completed 3 Widowed 4 Divorced White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Inspector Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Rush Hawbaker Alice Bryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Dorothea D. Hawbaker-Wife</u> Ontario Drive Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Greenlawn Mem. Park Nov.29,2010 Williamsport, Maryland Sonature of Fineral S Osbarne Luneralty Home, P.A. 425 S. Conococheague St.Williamsport,MD 21795 enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ 6 0 79 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death signed by the 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No 1 Tyes Other: Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Sulcide Investigation ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral C Medical 29a. Certifier 1🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d. Date signed (Month, Day, Year) 0/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nov. 23, 2010 Catherine Kane Hernick 1330 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's 6816 Kerman Road Seabrook Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Nov 24, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. **Director** 201-12-6876 Philadelphia.PA 83 1926 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Seabrook 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6816 Kerman Road 20706 USA 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White "natural" Specify. 3₺ Widowed 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Healthcare Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ James Kane Margaret McFeeley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health item 27 i Nicholas Hernick - Son 5817 Silent Sun Place, Clarksville, MD 21029 or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12/3/2010 Gate of Heaven Cemetery Silver Spring, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ Atherosclerotic Cardiovascu disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): If any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as nding IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth ∠ □ 1 0000. □

Pregnant at time of death

Unknown ō in the past 12 months? Month Day ed by the a 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner2 1. Yes 2 No Other: Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending hours after death. Ineral Director: A 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) November 26, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month

MOA3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mouth 11/50,5010, Physician/ Betty Ann Hampton 75:50 bw Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George's Clinton Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 💢 F 08/16/1934 Director 578-42-7018 76 DC Usual Residence of Decedent or 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 X Yes 2 No Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12600 Applecross Dr. 20735 AZU 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Marken. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Dept. of Defense Documetation Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Jeff Taylor Lillie Mae Fowler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16300 Whitehaven Rd., Silver Spring, MD 20906 Barbara J. Boney / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1

∠Burial 2

Cremation 3

Removal from State incoln Memorial Cem. 11/27/2010 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Dicenses 22. Name and Address of Facility Strickland Funeral Services 23a. Part T. Enter the disease, or complications that caused the Approximate shock, or heart failure. List only one cause on each ine. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Suquentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury by the attending physician and tached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No death? certificate 1 Yes 2 No completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, Director: After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Records, **Division of Vital** To the Hospital or Attending within 24 hours a To the Funeral I

Box 68760

P.O.

State Registrar

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryl				Mental Hyg	giene	10 3	0000
			State Registrar Decedent's Name (First, Middle, Last)	TCA	1/ /	rtificate of l	Jeath	2. Date of Dea			3. Time of Death
	Physici /Medic			Ettle	Hick	,		Month //	Day 20	20/0	0635 M
7	Examin		4a. Fecility Name (If not institution, give s	treet and number) .	. 1	4b. City, Town, or	Location of Deat		4c. Count	y of Death	c 0-
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		h y, Year)	9. Birthplac Country Maryla	
	Director		225-32-7579 Usual Residence of Decedent		02			103/17/1	920		
	ahow	o.	10a. State 10b. County		City, Town or Lo	ocation				100	. Inside City Limits 1 AYes 2 □ No
	r 28a-1	Director	MD Wicomico 10e. Street and Number	Sa	alisbury	10f. Zip Code			10g. Citizen of	What Country	7
	23a o	ralD	351 Deer's Head Ho			21802				SA	- Indian
	n 72 hours after death with the Maryland *natural*, or Items 23a or 28a-f ahow odical Exertinet must be notified at	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ∑No	:	Was Decedent of H If Yes, specify Cuba		pecify Yes or No- to Rican, etc.)	- 14. Ha Bla	ce - American ack, White, etc	
21215-0036	ours at	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Speci	WIII	
15-0	- 12	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a. Dece (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wo f)	rking	16b. Kind of E	Business/Indus	stry
212	filed within Hygiene. other than ont, in a Max	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		maker			Domest	tic	
	ed fa p	Ве	17. Father's Name (First, Middle, Last)					m <i>e (First, Middl</i> e,		me)	
Maryland	d 2 should the and Ment 7 is marked traumatic	10	Norman Peppler 19a. Informant's Name/Relationship (Type	oe, Print)	19b. Maili	ng Address (Street a		orence La ural Route Numbe		n, State, Zip Co	ode)
	nd 2 lith a 27 is		Stacey Carpenter /	granddaugh					Anne, N	MD 2185	53
altimore,	t of H if		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State		osition (Name of matory or other place	1	Date	20c. Location		
ıltim	E 68 3	1	4 □Donation 5 □ Other (Specify)21. Signature of Funeral/Service License			e Cemetery Name and Addres Illiams F	100		wacnapr	eague,	Virginia
Ba	permit. Depart Import any inj		Much. OA	Dean	_ 9	4 Market	St., P.C	. Box 21	8, Onar		
			23a. Part1. Enter the disease, or complishock, or heart failure. List only on		death. Do not en	ter the mode of dyin	ng, such as cardia	c or respiratory ar	rrest,	lr.	pproximate nterval Between onset and Death
j.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cor		mentio				y	ears
И	Examiner		Sequentially list conditions, b								
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a sor	nsequence of);						
ó	be executed sicien and burial-transit		that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):						
68760,	9 2 9	dical	d								
Box 6	sath certificate be attending physici for use as the bu	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐		□Ectopic pregnancy	,			ate of delivery	
.O. B.		by Physician/Med	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐Pregnant at time		Other (specify)			M	Ionth D	ay Year
Δ.	ires that the d signed by the d be detached	y Phy	Part II. Other significant conditions con				en in Part I.	23e. Did to	obacco use cor	ntribute to the	cause of death?
Records,	w requires been sign should be	ted b	Coronar	y Arter	7/ Va.1.	vulor U) staje	101	Yes 2 No	3 Probab	ily 4 □Unknown
Secc	e faw r has be je 2 sh	Completed	Hyperta	11 11				24a. Was autop perio	an 24b.	. Were autops prior to comp death?	y findings available pletion of cause of
Vital F	ysician: The is certificate hi director, page	e Col	25. Was case referred to medical	Lri As			26 Place of De	1 ☐ Yes ath (Check only of	2 No	1 ☐ Yes 2	□ No
of Vi	hysicia this cert al direct	To B	avaminar?	lospital: 1 ☐ Inpatient	2 ER/Outpatie		er: 4 Downsing I	Home 5 □ Resid	dence 6 🗆 Ot		
	ding Ph h. After th funeral		27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	ar) 28b. Time o	Wor	yat k? Yes 2 ⊡No	28d. Describe I	how injury occu	ırred	
Division	Attence death death ector:	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, st			28f. Location (S City or Tox		ber or Rural F	Route Number,
Ö	ital or irs afte ral Dir iled in										
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	sician: To the best of my ner: On the basis of exa and manner stated.	y knowledge, dea mination and/or in	th occurred at the tire to the	me, date and plac opinion, death occ	e, and due to the urred at the time,	date and place	nanner as stat e, and due to th	ed. ne cause(s)
	To the To the Complex	Me	29b. Signature and title of certifier	12. H.D.		29c Licens	0 69 7	54	29d. Date sign	ed (Month, Da	ay, Year)
			P/6-7.10		//tom Cas) (f	Print	- 0 , /	/	1//0	0/00	1/0
	3 E.T		30. Name and address of person who es	tospo Tol	Cent-er	Sall	skury	, Mary 1	land o	21803	2
	Sta Regist		31. Date filed (Month, Day, Year) NOV 2 9 20	32. Registrar's S	Signature	backer		/			

DHMH 17 Rev 1/2001

		For State		ase Type or State o erFH,12/1/10	of Maryla	and / Depa		f Health	and N		/giene	Jible.	2020	a
		1. Decedent's Nam	e (First, Middle	e, Last)		w cer	uncate o	Deaui		2. Date of De		10_	3. Time of Death)
Physicia Medic		Susa			leho ———					Month Novem	Day ber 20,	Year 2010	5:55p	Л
Examin	er	4a. Facility Name (if Shad		4b. City, Town, or Location of Death Rockville				4c. County of Death Montgomery						
Funeral Director		5. Social Security Number 215-51-1703 6. Sex 1 M 2 XF 7. Age (In yrs. last birthday 41 Age (In yrs. last birthday 41 Age (In yrs. last birthday 1 Age (In yrs. la					If Under 1 Year If Under 24 Hrs. 8. Date of B Months Days Hours Min. Mov. Nov.				olace (State or Foreig try) enya	n		
permit. Page 1 and 2 should be filed within 72 hours after death with the Mayland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important if frem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	rector	10a. State M D	10b. County	ntgomery	10c.	City, Town or Lo	cation Rockville					1	0d. Inside City Limits	
	Funeral Director	10e. Street and Nur 644		eague Lane	9		10f. Zip Coo	20850			10g. Citizen of United			
	by	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	4 🔼 Divorced	Armed For ried 1 Yes If Yes, Given Year or Discontinuous Properties of the control of the contro	2 X No /e	1	Was Decedent of Yes, specify C	uban, Mexica	an, Puerto	ecify Yes or No- Rican, etc.)				
	e Completed	(Spe	cify only high	nt's Education est grade completed, College (1		(Give I life. D	dent's Usual Ockind of work do NOT use retire Finance	e during mo ed)		-	16b. Kind of B		dustry	
	To Be	17. Father's Name (I James	s Kara	ago Heho					her's Name ahab	e (First, Middle Wanji l	, Maiden Surnam ku Wam	akima	a	
nd 2 shou ealth and m 27 is m ner traum		19a. Informant's Name/Relationship (Type, Print mother Rahab W. Heho / wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1728 Evelyn Drive, Rockville, Maryland 20852												
rt. Page 1 agrithment of H rtant; If itel rjury or oth		4 Donation	☐ Cremation 5 ☐ Other (S		State	Langata	Cemet	ery	Dec.	Oate 4, 201		Cenya		
Depart Depart Import any ir	-3	21. Signature of Fur	neral Service L	Juanp	00/						uneral S Washing		e, Inc. C 20012	
h, sician/ Medical	er	23a. Part 1. Enter the shock, or hear Immediate Cause (disease or condition resulting in death)	rt failure. List c Final	complications that conly one cause on a	ch line.	chasic							Approximate Interval Between Onset and Death	_
Examiner		Sequentially list con	nditions,	b. BA			veek	5	inge	IV			12 mouth	5
an and rial-tradit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												
	- 1	55		d										
signed by the attending physician dbe detached for use as the buna	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 9 ☐ Unknown	months?		Birth 2 ☐ Fe nant at time o	etal death 3 🗌	Ectopic pregn Other (specify)					te of delive	ory Day Year	
nospiral or Attending Prysidan: The law requires that the death certificate be A hours after death. Funeral Director: After this certificate has been signed by the attending physici ited filled in by the funeral director, page 2 should be detached for use as the bu	হ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 3 Probably 4 Unknown												
certificate has been si rector, page 2 should	Completed									24a. Was auto perfo	psy ormed?	orior to con death?	sy findings available npletion of cause of	
sertifica ector,	Be	25. Was case referred to medical examiner? 26. Place of Death (Check only one)												
r this c	e: 10	27. Manner of Dea		28a. Date		28b. Time of	t 3 □ DOA 28c. In	ury at			dence 6 Other			_
death. tor: Aftu r the fun	Certificate:	3 Suicide	1 Setural 5 Pending (Month, Day, Year) injury wor 2 Accident Investigation M 1											
ours after eral Direc		4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Fig. 1) City or Town, State)												
Hin S	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												ed.
20		240	Efe	MD		skeuk,		370	24		NOVEM		-	2
		30. Name and addre	ss of erson v	who completed caus	e of death (Ite	em 23a) (Type, Pr	rint) Rox	Kuilk	6/	4d.	2085	0	20,2016	
State	-	31. Date filed (Month	n, Day, Year)	0010 37 Re	egistrar's Sign	nature	dist.			- (

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year - 24, 20/ 6 Novembe GERALDINE E. HAMMOND 0203 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Rockville HOSP tel Montgomiery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F MD (MD) Hours 220-40-4306 Director 04/2171943 Usual Residence of Decedent show 10a. State 10b. County Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1X Yes 2 □ No MD Montgomery Gaithersburg 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 7537 Laytonia Drive 20877 USA 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify. Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 12th Day Care Provider Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ernest Hoes Rosetta Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Hammond, Jr.-husband 7537 Laytonia Drive, Gaithersburg, MD 20877 20a. Method of Disposition 20b. Place of Disposition (Name of permetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) klamm Memorial Cemi 11/30/10 | Rockville, MD 21. Signatur Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Cardionyopa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tr insit Hospital or Attending Physician: The law requires that the death certificate be executed Arrhythmia
Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month ☐ Pregnant at time of death☐ Unknown Day Year detached the signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Non Insulin Dependent Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen Sepsis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No Hypotension this certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Certificate: To Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Gord D0055054 MD 11 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Ave Gaithersburg MD 20877 Attan Kasid 6045 MD 31. Date filed (Month, Day, Year, State NOV 2 9 2010

Registrar

23

0203

Geraldin

Hammond

10-08928			pe or Print i							.egib		
Richard Francis	Hes	ss, Sr. S 1-For State	tate of Maryla		artment d <i>rtificate d</i>			Mental	Hygiene			39211
Physici	an/	Registrar 1. Decedent's Name (First, Midd	dle.Last)		Timeate	Dealli			2. Date of D	Reg. Neath	10.	3. Time of Death
Medical Exam			Richard	F. Hes	s. Sr				Month Novemb	Da Der 21	у , 2010	1338 hrs
		4a. Facility Name (if not instituti	on, give street and n		<u> </u>	4b. City, To		ocation of Dea	ath		4c. County of Dea Allegany	th
Funeral		Western Maryland Health System Cumberland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(N							IM/DD/YYYY) 9. B	irtholace (State or		
Director		219-32-4130	7	Months Dove Hours Mir				,	eign country) PA			
		Usual Residence of Decedent					37 30	, 1,		77 211		
v any		10a. State 10b. County	Adams	10c. City	ittle	ation						10d. Inside City Limits
land f shov	tor				TUCIC					,		1 Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In profram: If item 77 is marked other than "natural", or items 23a or 28a-f show sinjury or other traumatic event, the Medical Examiner must be notified at once.	Director	106. Street and Number 10f. Zip Code 10g. Citizen of 10g. Citizen of 10g. Tip Code 17340						Citizen of What Co	untry?			
with th 18 23a e noti									14. Race - Ame	erican Indian, Black,		
death r item	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) WI							White, etc.			
after ral", o	by F	3 Widowed 4 Divorced if test sive tear 1 Yes 2 X No specify: Specify: Specify:								hite		
hours "natu	ted	15. Decedent's Education (Special Secondary (0-12)			16a. Decede during r	ent's Usual O most of worki	ccupationing life. D	n (Give kind o O NOT use r	of work done retired)	168	b. Kind of Business	s/Industry
)36 thin 72 ne. than edical	Completed	Elementery/Secondary (0-12) College (1-4 or 5+) 12 Public Facilitator Social							Social	Security Admin.		
5-0(led wi Hygier other		17. Father's Name (First, Middle	e, Last)		,		18		me (First, Middle	e, Maid	en Sumame)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Francis			Lan Mari						ldorff	
D 2 shoul and M 7 is m	2	19a. Informant's Name/Relation Jane Hess	snip (Type, Pnnt)								City or Town, Stat	vn, PA 17340
Baltimore, MD semit. Pages 1 and 2 shc opartment of Health and important: If item 27 is nijury or other traumati		20a. Method of Disposition			Place of Dispo	sition (Name			Date		c. Location - City o	
nor ages l at: If other		1 Burial 2 X Cremation	_	OIII State	crematory or o		ator	v 11	/29/10		Hampste	ad. MD
altir mit. F partme portau ury or		4 Donation 5 Other S 21 Signature of Funeral Service			22.	Name and A	ddress of	f Facility			PA	A 17340
		Tillard &	Julle or	ŶG.					34 Map		Ave. Li	ittlestown
Physician		23a. Part I. Enter the disease, o failure. List only one cause	e on each line.		. Do not enter	the mode of	dying, su	ich as cardiad	c or respiratory	arrest, s	shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		ies consequence o	nf):							Death
		Sequentially list conditions,	b									
	inei	if any, leading to immediate cause. Enter Underlying Cause		consequence o	nf):							
sit of	Examiner	Due to (or as a consequence of):										
xecuted n and l - transit	ल	UNPENDED	dAMENDED									_
50, te be e nysicia e buria	Medi	IF FEMALE:		outcome of preg	inancy						23d. Date of delive	~
68760, certificate be ex nding physician as as the burial	an/h	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month										Day Year
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Medic	1 Yes 2 No 9 Un	aknown 9 Unkn		eath 5 C	ther (Specif	ý)			1		Di
tal Records, P.O. Box 68760, cian: The law requires that the death certificate be ex certificate has been signed by the attending physician ector, page 2 should be detached for use as the burial		Part II. Other significant condi	tions contributing to	o death but not r	esulting in the	underlying c	ause give	en in Part I.	23e. Dio	tobacc	co use contribute to	the cause of death?
ires the signed of the de	d by								_	es 2	No 3 Pro	babiy 4 🗹 Unknown
ords w requ	plete									as an lopsy	utopsy findings available completion of cause of	
Records, The law requires ficate has been significate has been significate has been significate has been significate has been significant has been significa						performed? death? 1 Yes 2 No 1 Yes 2 No						′es 2 No
tal F cian: certifi ector,	Be	25. Was case referred to medica examiner?	Linealitate -				I OH	Death (Chec				
f Vil Physic er this ral dir	1 V Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence									er: Scene		
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the start cleath. **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact.	ion	1 Natural 5 Pen	ding Nov 21,	2010 (ar)	1200 hrs			2 No			d in auto (ATV	') accident
r Atte r Atte ter dea irectol	ficat	2 Accident Investigation 28e Place of Injury - At home, farm, street					factory, office building, etc. 2			28f. Location (Street and Number or Rural Route Number, City		
Div pital o ours afi	Certification:	4 Homicide determined (Specify) Other (specify) HC66 Box 23 Old Fields Road,							Fields Road, Ha	mpshire, WV		
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for u		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as										
To the within the comp	Medical	29b. Signature and title of certifi		29c. License number				29d. Date signed (Month, Day, Year)				
mes						O.C.M.E.				November 22, 2010		
my 12		30. Name and address of persor	n who completed caus	se of death (Item	23a)				·			
M		Ana Rubio MD. As	sistant Medical I	Examiner	111 Penn :	Street, Ba	ltimore	, MD 212	01			
C.	ata.	31, Date filed (Month, Day, Year)	32. R4	gistrar's Signatu	ire / /	. 1						

DHMH 17 Rev 1/2001 OCME 2006

Registrar

	}	Ph // Ex
	F Di	un
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
9	Phys /Me Exar	sic edi mii
	scuted	nd

1 - For State Registrar

	/Medical		KATHRYN VIOLET HAIR	DECEMBER 6 2010 /100	М					
A	Exami	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	ath 4c. County of Death						
	Funeral		7. Age (in yrs. last birthday) Treat In Grider 24 Th	rs. 8. Date of Birth 9. Birthplace (State or Forei	ign					
	Director		216-24-0657 1 M 2X F 95 Yrs. Months Days Hours Min	March 26, 1915 New York						
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limit	to					
	the Marylar 28a-f show	to	MD Kent Chestertown	13⊠Yes 2 □ N						
	or 28a	irec	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?	—					
	th with	a D	211 Richard Dr. 21620	U.S.A.						
	after dear or items	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puel	(Specify Yes or No- 14. Race - American Indian,						
36	s afte	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 ☐ Yes 2 No Specify:	orto Rican, etc.) Black, White, etc. Specify: White						
215-0036	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Medical Everifice inset to rutified at	ed k	3 LXWidowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation							
215	hin 72 e. an "ne	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of woll life. DO NOT use retired)	orking 16b. Kind of Business/Industry						
21	filed within Hygiene. rther than "	E O	3 Registered Nurse	Doctors Office						
pu	be file tal Hy d oth event	B		ame (First, Middle, Maiden Surname)						
<u> </u>	2 should be fi and Mental H is marked ot aumatic ever	၉	Joseph Nicodemus Eva Lo							
Maryland	nd 2 sh alth and 27 is n ir traun	1		Rural Route Number, City or Town, State, Zip Code)						
	1 and 2 Health tem 27 i			man Hwy. Chestertown, MD.2162	:0					
m 0	Pages ent of nt: If i		20a. Method of Disposition 1 🖾 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Pk.	, , , , , , , , , , , , , , , , , , , ,						
Baltimore,	permit. Pages 1 and 2 Department of Health Important: if item 27 i any injury or other tra once.									
ä			M00510 Galena Funeral Ho	ome of Stephen L. Schaech C. Galena, MD. 21635						
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of lying, such as cardia shock, or heart failure. List only one cause on each line.	n. Do not enter the mode of rying, such as cardiac or respiratory arrest, Approximate Interval Between						
	Physician	85	Immediate C. Use (Final disease or condition							
	/Medical Examiner		resulting in death) Due to (or e a consequence of):	ioni ac-	3					
п	Lxammer	<u>.</u>	Sequentially list conditions,	b. Due to (or as a consequence of):						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
oʻ	exec an an	Exa	that initiated events ' c		—					
68760,	ate be nysicia he bur	Sal	d							
% %	eath certificate be executed attending physician and for use as the burial-transit	sician/Medical	IF FEMALE:							
Вох	death o e attend id for us	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year	W					
0	e law requires that the de has been signed by the e 2 should be detached	ysic	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown							
σ,	s that ned b	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown						
ğ	en sig	Completed by	Alus rend Insufficiency							
ဝ၁	law re as be	plet	Atual Vibrillation	24a. Was an 24b. Were autopsy findings available	е					
<u> </u>	The ate his page	ĕ	7	autopsy prior to completion of cause of death? 1 □ Yes 2 ☑ No 1 □ Yes 2 ☑ No						
/ita	siclan: The certificate rector, pag			1 □Yes 2 □No 1 □Yes 2 □No ath (Check only …e)						
of \	Physical this call dire	၉	1 Yes 2 No	Home 5 ☐ Residence 6 ☐ Other (Specify)						
nc On	ding F h. After funera	<u>ë</u>	27. Manner of Death 1. Natural 5 Pending (Month, Day, Year) 28b. Time of Injury Work? 28c. Injury at Work?	28d. Describe how injury occurred						
Division of Vital Records,	deatl ctor: y the	lica	2 Accident investigation 3 Suicide 6 Could not be determined determined determined	20t Legation (Charles LA)						
ă	al or safter	Certification:	4 Homicide determined building, etc. (Specify)	8f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospital or Attending Physician: The law requires that within 24 hours after death. To the Funeral Director: After this certificate has been signed to completely filled in by the funeral director, page 2 should be detained.		29a. Certifier (Check only Amedical Examiner: On the basis of examination and/or investigation in my only in death according to the page of examination and/or investigation in my only in death according to the control of the cont	Le, and due to the cause(s) and manner as stated.	\dashv					
	the H hin 24 the F nplete	Medical	one) and manner stated.	surred at the time, date and place, and due to the cause(s)						
	5 7 6 9 9 9	2	29b. Signature and title of certifier 29c. License number 29d. Date signer (Month, Day, Year)							
•			1 K (Onl., MD) U07102	7 12/06/2010)					
				STERTOWN MD						
	Stat Registra	~	31. Date filed (Month, Day, Year) DEC 1 3 2010 32. Registrar's Signature 33. Registrar's Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 10:10pm Sondra Isquith Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens - Riderwood Prince George's Silver Spring Social Security Number 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) New York **Funeral** 1 🗌 M 2 🛛 F Days Hours Min Director 094-28-9091 76 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits Silver Spring 1 Yes 2 X No Maryland Montgomeru 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3118 Gracefield Road, T-01 20904 u.s.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🗓 No Specify: "natural", 3 X Widowed 4 Divorced Specify: Year or Dates White the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ should be Julius Radnoff Helen Weisman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Isquith - Son Page 1 and 2 4578 Kingscup Court. Ellicott City, MD 21042 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō Important: If it any injury or o cemetery, crematory or other place) Burial 2 Cremation 3 K Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hebron Cemetery 11/28/2010 Queens. New York 21. Signature of neral Service Lice 22. Name and Address of Facility Hines-Rinaldi Funeral Home. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. terval Between Immediate Cause (Final Onset and Death Physician/ Renal Failure Acute disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Chronic Obstructive Pulmonary Disease sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed rate has been signed by the attending physician and page 2 should be detached for use as the burial-upper that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No 3 Ectopic pregnancy Month 5 Other (specify) 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate performed? death? 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Other: 4 K Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred X Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Vertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ပ 10 an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Julaine Harding

NOV 26 2010

31. Date filed (Month, Day, Year)

CRNP

3110 Gracefield Road, Silver Spring,

Maryland 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Margaret Annabelle Jackson Mpnth 24-2010 0500 Ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Havre de Grace Examiner 4c. County of Death Harford 626 Water Street Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign MAYY) Land **Funeral** 8. Date of Birth 212-20-7068 1 □ M 2 🛣 F Months Days Hours Min. 02001 6Day 925 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Indical Examinating an analysis of all had all 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Harford Havre de Grace Director 1 Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? United States of America 10f. Zip Code 21078 626 Water Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 □Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No þ Specify: Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Family 17. Father's Name (First, Middle, Last) Alfred A. Kennedy B 18. Mother's Name (First, Middle, Maiden Surname) ဂ 19a. Informant's Name/Relationship (Type, Print) James Jackson, Sr. (son) 1320 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
LOCUST POINT ROAD, ELRTON, MV 27921e, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place),
Harford Memorial Gans 11-29-2010 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Aberdeen Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Zellman Functil Home, P.A. 21078 21. Signature of Funeral Se 123 S Washington Street, Havre de Grace, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the busine Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown gnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autonsy performed? 1 ☐ Yes 2 □₩6 Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 ☑ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 | Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 24 hours after death Pruneral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D-15 994 11 - 29 - 1030. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leticia S. Galvez, M.D., 625 S. Union Ave., Havre de Grace, MD

Registrar
DHMH 17 Rev 1/2001

State

82. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JAMES ARTHUR JENKINS Year Medical **WOVEMBER** 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS TIMONIUM BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MARYLAND **Funeral** 8. Date of Birth Days Months 219-22-3989 1 🕅 M 2 🗆 F Hours Min (Month, Day, Year) FEB 11 - 1928 **Director** 82 Usual Residence of Decedent show 10a. State with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Examiner must be notified MARYLAND HARFORD ABERDEEN 1 XYes 2 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 901 BARNETT LANE, APT 407 21001 UNITED STATES hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian ō ģ 1 Never Married 2 Married Black, White, etc. 1 X Yes 2 □ No If Yes, Give Maryland 21215-0036 1 Yes 2 XNo Specify: "natural", Completed 3 X Widowed 4 Divorced BLACK Specify: Year or Dates. 1950-52 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N College (1-4 or 5+) CUSTODIAL ENGINEER VA HOSPITAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JAMES AUGUSTUS JENKTNS FLORENCE GRIMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA A. EDWARDS / DAUGHTER 819 CLOVER LEAF COURT, EDGEWOOD, MARYLAND 21040 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) GARRISON FOREST VETS. 12/9/10 OWINGS MILLS, MD Signature of Funeral Service Licensee 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME,
552 LEWIS STREET, HAVRE MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ BLADDER CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 4 Pregnant 9 Unknown Pregnant at time of death Month Day Yes 2 No. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 24 hours after death.

• Funeral Director. After this certificate I aleted filled in by the funeral director, pagr performed? Yes 2 X No 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 🗶 No Hospital Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident Investigation 1 Yes 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 2 Medical Examiner: On the pasts or examination and on investigation, in this opinion, seath occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29c. License number 29d. Date signed (Month. Day. Year)

5† IVA

NOVEMBER

JENKINS

DHMH 17 Rev 7/2009

Registrar

30. Name and address of

JACKIE JONES.

31. Date filed (Month, Day, Year)

2300 DULANEY VALLEY RD.

son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CRNP

2010

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 3:35 P Louise Frances Koontz 247 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Gilchrist Hospice Care Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday Birthplace (State or Foreign Country)
 MD 8. Date of Birth 1 □ M 2 🛣 F Months Days Hours Min 127571933 214-30-5083 76 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 🔀No MD Clarksville Howard 10e. Street and Number 10g. Citizen of What Country? Funeral 5419 Harris Farm Lane 21029 United States death v 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 🛛 No Specify: "natural" Completed 3 XWidowed 4 ☐ Divorced Specify White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. "Important: If item 27 is marked other than" amy injury or other traumatic event, the Mee once. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Byrnes Alice Bavis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Becraft - Daughter 5419 Harris Farm Ln. Clarksville, MD 21029 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Good Shepherd Cem. Ellicott City, MD 12/1/2010 21. Signature of Funeral Service Libensee 22. Name and Address of FacilityHarry H. Witzke's Family F.H. Inc M01411 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death Metastalic reast disease or condition KCOIN N Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🖾 No Month Pregnant at time of death Day Year been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 1 ☐ Yes 2 ☐ No Yes 2 No ours after death.

eral Director: After this certificatilled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No Other: 유 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date/signed (Mpnth, Day, Year) D71040 MD 27 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 FUMAR N Charles 6701

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month,

NOV 2

32. Registrar's Signature

research

TOWNSON MD

2/204

			1 - For State Registrar	State	n warytar		rtificat				nentai myg	eg. No.		
20	Physicia /Medic		Decedent's Name (First, Middle, Cl	Last) narles Ke	y Jr.						2. Date of Dea Month November		2010	3. Time of Death 16:30 M
	Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City,	Town, or	Location	of Death		4c. C	ounty of Death	
		u	Washington Ad				Millado		koma				Montg	
	Funeral			6. Sex 1 🛣 M 2 🗆 F	7. Age (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day April 20	Year)	9. Birth Cou	place (State or Foreign ntry) DC
	Director		578-44-5373 Usual Residence of Decedent		75						APILL 2	ل و ا	737	DC
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28e-f ehow other traumatic event, the Medical Examinst must be notified at	or	10a. State 10b. County DC		10c. Ci	ty, Town or Lo	ocation		Was	hing	ton			10d. Inside City Limits 1 X Yes 2 ☐ No
	the 28e-	Funeral Director	10e. Street and Number				10f. Zip	Code				0g. Citize	en of What Cou	ntry?
	3a or		2855 Bladensbur	o Rd. NE	#416				2001	18			United	States
	ms 2	Jera	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.	Was Deced	lent of H			ecify Yes or No- Rican, etc.)	14	1. Race - Ameri	
0	after or ite	Ē	1 Never Married 2 Marrie	Armed For ad 1 ☐ Yes If Yes, Gr	2 XNo	1	1 ☐ Yes		Specify:		Hican, etc.)		Black, White	rican
3	ralf, o	i by	3 Widowed 4 Moivorced	Year or D	ates:		TLI TUS .	2123-190	эрөспу.					erican
ה ה	72 ho	Completed	15. Decedent's (Specify only highest	s Education grade completed)		16a. Dece (Give life.	dent's Usua kind of wo	i Occupa	ation during mos	t of work	ing	16b. Kind	d of Business/Ir	ndustry
7	ithin Ne.	du	Elementary/Secondary (0-12)	College (1-4or 5+)									
V	ygier ygier her th	Ö	8th	1		DC S	Sanita	atio:			e (First, Middle, i	Majdam C	Gover	nment
2	be fi	Be	17. Father's Name (First, Middle, L		17				18. Mothe	ers Nam				
Š	d Mer nark	ပ္	19a. Informant's Name/Relationsh	Charles	Key	10b Mailie	a Addrasa	(Stroot)	and Numbe	2	Po11: al Route Number			- Code)
2	d2 sh th and 7 is n traur		Tawanna Key -				3 27tl				ple Hill			
บ	1 and Health em 2		20a. Method of Disposition	Daugnter	20b. I	Place of Dispo							ation - City or T	
2	Pages nent of int: If it iry or o		1 Burial 2 TCremation		State	_			1	10/				
Dallinor	artme ortan Injury		4 □ Donation 5 □ Other (Sp. 21. Sign ure of Funeral Service L			Lee's	Crema Name an				5/2010 ewart Fu			Maryland
0	permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other once.		1 Shar	400	With the	11 11					NE Wast			20019
è	='		23a. Part1. Enter the disease, or of shock, or beart failure. List of	omplications that only one cause on e	caused the dear	th. Do not ent	er the mod	e of dyin	g, such as	cardiac	or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			CDO	1 6	ON	on cas	maile.	n Duse	20.50		Onset and Death
1	/Medical		resulting in death)	Due to	(or as a consec	uence of):	CO		OV 11 3	CV	4112:34			Y-1007
	Examiner		Sequentially list conditions,	b										
	p is	Inel	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	quence of):								
	lificate be executed g physicien and as the burial-transit	Examiner	that initiated events resulting in death) Last	c	(or as a consec	ruanaa at):								
Š	cien cien curial	Ē		Due to	(OI as a COIISEC	quarica or).								
0	physi the l	edical	`	d.										
S	ding se as		IF FEMALE:	23c. If yes, ou	tcome of pregna	ancv						27	ld. Date of deliv	00/
2	iclen: The law requires that the death cert certificete has been signed by the attending rector, page 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months?	1☐Live t	oirth 2 Feta	aldeath 3 [Ectopic pr Other (sp					20	Month	Day Year
į	the d y the tched	ysl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn				,,						
_	that ned b		Part II. Dther significant condition	s contributing to d	eath but not res	sulting in the u	nderlying c	ause give	en in Part I		23e. Did to	oacco us	e contribute to	he cause of death?
3	quires n sign	Completed by	End Stope Re	usel Di	SERED	Hem	odes	ley	is		1 🗆 Y	es 2 🗆	No 3 ☐ Pro	bably 4 Unknown
5	w rec	lete	Duna Lu	mal. In	An Free	Atric	IFIL	na : 1	ati	WI O	24a. Was a	n		opsy findings available
ב	he la e has age 2	m C	a diameter	Col		1.1.4	1112		William Co.		autops	ned?	death?	empletion of cause of
9	ifficet or. p	Ö	25. Was case referred to medical	TELLIVI	e Vie w	hiero	n Do	1361	26 Place		1 ☐ Yes	No No	1 🗆 Yes	2LJ N0
>	ysick s cer direct	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DC	A Othe			me 5 Reside	-	□Other (Speci	fv)
5	g Ph er thi		27. Manner of Death	28a. Date	of Injury th, Day Year)	28b. Time of Injury		Bc. Injun	at		28d. Describe ho			
5	ath. r: Aft	atlo	2 Accident 5 Pending investigation		iii, buy roui,	injury	М		Yes 2	No				
2	r Atte	Certification:	3 Suicide 6 Could no 4 Homicide determin	and 286. Place	of Injury - At h	ome, farm, str	eet, factory	, office			28f. Location (Si City or Town		Number or Rur	al Route Number,
2	itel o													
	To the Hospitel or Attending Physiclen: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the xaminer: On the b and man	best of my kno asis of examina ner stated.	owledge, death ation and/or in	h occurred vestigation,	at the tim in my of	ne, date an pinion, dea	id place, th occur	and due to the c red at the time, d	ause(s) a ate and p	nd manner as s place, and due t	stated. o the cause(s)
	Mithin 2	Me	29b. Signature and title of certifier				290	. License	number		2	9d. Date	signed (Month,	Day, Year)
	- > - 0		10000	(le. 2)	no in (00	185	12		Nov	embo.	on Dair

State Registrar

31. Date filed (Month, Day, Year) NOV3 0 2010

MS-4223 Queensbury Rd Hye theille MM 2018;

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. mend #18 per Fh G910 12/13/10 TT State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Year HAROLD KELLY JOSEPH 8:03 P M Medical DECEMBER 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 D F Months Days Hours Min. Country) Maryland 10726 216-12-5530 Director 90 Usual Residence of Decedent 28a-f shov 10a. State 10b. Count notified at 10c, City, Town or Location Director 10d. Inside City Limits MD. 1 Yes 2 No Harford Baldwin 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 2705 Greene Road 21013 United States within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 XNever Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Specify: White permit. Page 1 and 2 should be filed within 72 hour popartment of Health and Mental Hygiene. Important if item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Blacksmith Equipment Repairs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ William James Bessie Bessie Kelly Wilkus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21111 Sterling J. Lytle (Nephew 3209 Jarrettsville Pike Monkton, 20a. Method of Disposition Date 8, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place Dec 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 2010 Maryland Hampstead . Signature of Funers Wilce Lice 22. Name and Address of Facility E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACUTE MYOCARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ 1 ☐ Yes 2 🔀 No Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work' Accident 1 Tes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certi 29d, Date signed (Month, Dav. Year) 200 D 37254 10

Registrar

State

OSLER

DRIVE, TOWSON, MARYLAND

21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

7601

32. Registrar's S

BOON POH LIM,

3 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of N	Marylan	•	artment <i>tificate</i>			d Mental I	, ,			
	Physicia	an/	Decedent's Name (First, Middle, Las	t)			inoato	0, 00	-	2. Date of		201	U	3. Time of Death
	Medi	cal		Cover Lew								iber 2	2, 2010 Ye	ear	1:50 р м
	Examin	ner	4a. Facility Name <i>(if no</i>		street and number,	,			own, or Lo hesda	ocation of D	eath		4c. County of D		
	Funeral Director		5. Social Security Num 211–40–65	86 1	7. A	Age (In yrs. Id 60	ast birthday) Yrs.	If Under 1 Months		f Under 24 I Hours M	lin. DeC• 1		9 .	Birthpi Count	ace (State or Foreign
	and show	5	Usual Residence of De 10a. State 1	ob. County		10c. Cit	y, Town or Loc	ation						10	d. Inside City Limits
	Maryla 28a-f	Director	MD	Montg	omery		Bethesda	a .							1 🗌 Yes 2 ื No
	ith the 23a or st be n	ralD	10e. Street and Numb					10f. Zip C					Citizen of What	t Count	ry?
	leath w	Funeral	11. Marital Status	IIK DLIVE	12. Was Deceden	t Ever in U.S		2081 /as Deceder	nt of Hispa	anic Origin?	(Specify Yes or I		SA 14. Race - A	America	n Indian,
9000	urs after d ural", or l	þ	1 ☐ Never Married 3 ☐ Widowed 4 [Armed Forces 1 Yes 2 If Yes, Give Year or Dates.			Yes, specify Yes 2		Mexican, Pu Specify:	èrto Rican, etc.)		Black, W	Vhite, e	
Maryland 21215-0036	e filed within 72 hours after death with the Maryland tal Hyglene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	(Specification (Speci	15. Decedent's Ed y o <i>nly high</i> est <i>gra</i> day (0-12)	de completed) College (1-4 or	5+)	life. DC	ind of work NOT use re	done durir etired)		vorking	16b	. Kind of Busine		•
2 pد	filed wi al Hygid d other event, t	æ	17. Father's Name (Fin	st, Middle, Last)	4		Busin	iess Ow		3. Mother's I	Name (First, Mide	dle, Maide		lvert	ising
ylar	uld be Menta narked natic e	욘	Millard (Virgin				
, Mai	nd 2 shorelealth and m 27 is n		19a. Informant's Name William Ar	thur Lewis			19b. Mailing 7224	Address (S	Street and rk Dri	Number or ve, Be	Rural Route Nun thesda, M	nber, City D 208]	or Town, State, L 7	, Zip Co	ode)
Baltimore,	permit. Page 1 and 2 should be files Department of Health and Mental H Important: If item 27 is marked of any injury or other traumatic ever once.		20a. Method of Dispos 1 Durial 2 😾 4 Donation 5	Cremation 3	Removal from Stat	e c	lace of Dispos emetery, crem ropolita	atory or other	er place)	No	Date V. 24 2010		Location - City Lexandria		
Ball	permit Depart Impor any in	K ją	21. Signature of Funer	al Service License	Dad ") 0	22. Fr 500	Name and A ancis Unive	Address of J. Col rsity	f Facility Llins F Blvd.	uneral Hom	ne Tno	٠		
				allure. List only on	lications that cause e cause on each lin	ed the death ne.	n. Do not enter	the mode o	of dying, su	uch as card	iac or respiratory	arrest,			Approximate Interval Between
	Medical		Immediate Cause (Fin disease or condition resulting in death)	al 🌈	Advanced Due to (or as									1	Onset and Death
	Examiner	<u>.</u>	Sequentially list condi	tions.	b. ———										
_	nsit	Examiner	if any, leading to imme cause. Enter Underlyin Cause (Disease or imp	ediate ng	Due to (or as	a consequ	ence of):								
	icate be executed physician and sthe burial-transit	I Exa	that initiated events resulting in death) Las	t I	Due to (or as	a consequ	ence of):							+	
260	ate be physici the bu	edical			d									_	
Records, P.O. Box 687	ath certif attending for use a	Physician/M	IF FEMALE: 23b. Was decedent pre in the past 12 moi 1 ☐ Yes 2 🛣 N 9 ☐ Unknown	nths?	3c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3 🗌	Ectopic pre Other (spec					23d. Date of Month		/ ay Year
<u>0</u>	that the	by Ph	Part II. Other significa	nt conditions cor	ntributing to death	but not resu	ulting in the un	derlying cau	ıse given iı	n Part I.	23e. Die	d tobacco	use contribute	to the	cause of death?
ds,	requires that the de been signed by the should be detached										_ 1[Yes	2 🙀 No 3 □	Proba	bly 4 🗆 Unknown
900	law re has be ge 2 sh	Completed										topsy	prior	to com	y findings available pletion of cause of
E E	siclan: The la certificate ha irector, page (25. Was case referred t	o medical			_		26 Place	of Death (Cl		rformed? s 2 K	No 1 🗋	Yes 2	□ No
Ĭ	hysick his cer Il direct	To B	examiner?	lo H	ospital: 1 □ Inpat	tient 2 🗆 E	ER/Outpatient		Othor:		Home 5X Re	sidence	6 ☐ Other (Sp	ecify)	
n o	ding P th. After t funera	cate:	27. Manner of Death 1 Natural 2 Accident	Pending	28a. Date of inju (Month, Da		28b. Time of injury	28c.	Injury at work?	2 🗆 No	28d. Describ				
Division of Vital	Hospital or Attending Physician: The 24 hours after death. Fruneral Director: After this certificate teted filled in by the funeral director, page	Certificate:		Investigation Could not be determined	28e. Place of Inj building, et	jury - At hon c. (Specify)	me, farm, stree			2 LI NO		(Street a	nd Number or I e)	Rural R	oute Number,
_	To the Hospital or within 24 hours after To the Funeral Dire completed filled in E	Medical	29a. Certifier 1 🔀	Certifying Physic	cian: To the best of	f my knowle	edge, death oc	cured at the	time, date	e and place	, and due to the	cause(s) a	and manner as	stated.	e(s) and manner stated.
	o the I	Me	only one) 3 29b. Signature and title	Certifying Nurse	Practioner: To the	Dest of my	knowledge, de	ath occurred	opinion, de l at the time cense nun	e, date and p	u at the time, date olace, and due to	the cause	(s) and manner	as state	ed.
	ا گا		> //	MA	1//	MY	1	Was		0101030	768		ate signed (Moi • 24. 20]		y, rear)
			30. Name and address Patrick Byr	of person who co	mpleted cause of o 020 Hamake	leath (bem i	23a) (Type, Prir ‡101,	rt) Fairf a	x, VA	22031		_			
	Stat Registra	_	31. Date filed (Month, D				ire And								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ For State	of Maryland /				and M	ental Hy	giene)	0		
			Registrar	_	Cer	tificate of D	eath			Reg. No	201	0	3922L)_
П	Physicia	an/	1. Decedent's Name (First, Middle, Last)						2. Date of De Month	Da	y Ye	ar	3. Time of Death	
~ >	Medic Examir		Chae Bong Lee 4a. Facility Name (if not institution, give street and nun	nber)		4b. City, Town, or	Location o		<u>Novemb</u>		4, 20		7:25 A ^N	Л
	LXamii	ICI	410 Lakelands Drive	,			hersk			40	County of I		erv	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	oirthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Bir			Birthpl	ace (State or Foreig	n
	Director		609-74-3825 1 □ M 2 X F	92	Yrs.	Months Days	Hours	Min.	Month, Da	191	8 1	Counti Vort	h Korea	
	nd thow at	۱	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loc	ation						10	d. Inside City Limits	
	Aaryla 8a-f s tified	ect	Maryland Montgomery		Gai	thersbur	ď					"	1 X Yes 2 □ N	
	the N	٥	10e. Street and Number		<u> </u>	10f. Zip Code	9			10g. Ci	tizen of Wha	t Count	ry?	
	s 23e	Funeral Director	410 Lakelands Drive			208	78			S	outh I	ore	a	
	r item		Armed Fo		13. W	as Decedent of His Yes, specify Cubar	panic Orig	jin? (Spec , Puerto R	ify Yes or No- ican, etc.)		14. Race - A			
36	e filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 3 🛣 Widowed 4 ☐ Divorced Year or De	e	1	☐ Yes 2 🕱 No	Specify:		,		Specify:			
ŏ	hours natur lical B	Completed	15. Decedent's Education		6a. Decede	ent's Usual Occupa	tion	_		16b K	ind of Busin	Asi		
218	in 72 e. nan "ı	E G	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1		(Give ki	nd of work done du NOT use retired)		of working	9	100. K	ind of Busin	ess inci	astry	
2	d with ygien her tl nt, the	Be C	12		_	Homemak	er				Own E	Iome		
Maryland 21215-0036	d 2 should be filed value and Mental Hyg 127 is marked othe r traumatic event,	To B	17. Father's Name (First, Middle, Last)						(First, Middle,					
Ž	2 should be file Ith and Mental I 27 is marked of traumatic eve	ľ	Beyung Yong Lee 19a. Informant's Name/Relationship (Type, Print)					yung			<u>im</u>			_
	2 shou lith and 27 is m r traum		Yun Wha LaMagna/daught			Address (Street ar akelands								
Ē,	1 and		20a. Method of Disposition	20b. Place	of Dispos	ition (Name of			ite		ocation - City		nd 20878	
	Page nent o ant: If Iry or		1 ☐ Burial 2 【文Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	Otato		atory or other place Lev Cremat	•		Carrier of					
ati	permit. Page Department (Important: If any injury or once.		21. Sig Jure of Funeral Service Licensee	TIME (22:	Name and Address 1ng Home	of Facility	11/2	. Co	WOO	Dabine	نا⊻ا م	aryland	- 1
m	89 = 89	8	Quanto R Thomas	M009	<u>571.Be</u>	verly L.	Heck	rotte	P.A.	_Clá	er.O. E	ox 11e	/84 _ MD 2102	9
			23a. Part V Enter the disease, or complications that c shock, or heart failure. List only one cause on ea	aused the death. Do	not enter	the mode of dying,	, such as c	ardiac or	respiratory ari	est,		1	Approximate nterval Between	
P	hysician/ Medical		Immediate Cause (Final disease or condition Demo	entia									Onset and Death	
mark.	Examiner		resulting in death) a. Due to (or as a consequence	e of):									
		Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	e of):		_					+		\dashv
1	ansit	Examin	cause. Enter Underlying Cause (Disease or linjury		,-							-		
	executed an and rial-transi	Ex	that initiated events c. resulting in death) Last Due to (or as a consequence	e of):							+		_
၁	sate be executed physician and the burial-transit	edical	d											_
289	ing pleas t	/Me	IF FEMALE:									_		
Rox	atn ce attend for us	Physician/M	in the past 12 months?	come of pregnancy Birth 2 Fetal dea nant at time of death	ath 3	Ectopic pregnancy Other (specify)				1	23d. Date of Month		/ ay Year	1
ň	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		5 🗆 '	Other (specify)					MOINT	D	ау төаг	
л О	ned by deta	by P	Part II. Other significant conditions contributing to de	ath but not resulting	g in the und	derlying cause give	n in Part I.		23e. Did to	bacco us	se contribute	to the	cause of death?	٦
S,	n sign	ed b							1 🗆 🗎	res 2	□ No 3 □	Proba	bly 4 🗆 Unknown	,
o D	w red	plet							24a. Was a		24b. Were	autops	y findings available	ᅱ
Hed F	ate ha	Completed							autop perfor	med?	death	to comp 1? Yes 2	oletion of cause of	
Vital Records,	entific ector,		25. Was case referred to medical examiner?			26. Plac	e of Death	(Check o		2 20 140		703 Z		
	this c	2		npatient 2 ER/O			4 ∟ Nurs	sing Home	5 🔀 Resid	ence 6	Other (Sp	ecify)		
	After funer	Certificate	1 Natural 5 ☐ Pending (Month		Time of injury	28c. Injury a work?		- 1	d. Describe h	ow injury	occurred			
VISION	ctor:	≝	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place 6	of Injury - At home, fa	arm. stree		es 2 🗆 N		f. Location (Si	*** ** * * * *	Alumbanan	D		4
	s after			g, etc. (Specify)	, 01.00	i, idotory, orribo		20	City or Town		Number or	nurai n	oute Number,	
- ÷ideo	The hospital or Authoring Priystoan: The law requires that the death certhics within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis	st of my knowledge,	, death oc	cured at the time, d	late and pla	ace, and o	due to the cau	se(s) and	manner as	stated.		\dashv
4	the F		only one) 3 Certifying Nurse Practioner: T	the best of my know	wledge, dea	ath occurred at the t	ime, date a	urred at the ind place, a	e time, date ar and due to the	d place, cause(s)	and due to the and manner	ne cause as state	e(s) and manner state d.	:d.
ا ا	Ğ 4 ₹ 5		29b. Signature and title of certifier			29c. License n			2	29d. Date	signed (Mo	nth, Day	v, Year)	1
		-	y Colonal D		~	D371	42			Nov	ember	24,	2010	
3			30. Name and address of person who completed cause	, , ,		,		_						
	State	е		gisti ai s Signature 🥷	TAG	Rockvi II	e, Ma	ryla	nd 208	50				\dashv
	Registra	r	1107 6 3 2010	neur B.	100	ues								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10:05 AM Physician/ 2010 awver Medical 4a. Façility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ashington (Haserstown Washing Tow (Junty Hospin-JUNTU 9. Birthplace (State or Foreign Country) New York Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 6. Sex 8. Date of Birth (Month, Day, Year) Sept. 24 1 X M 2 □ F Days Hours Min. Director 110-22-4007 79 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fitem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ▼ No Washington Maryland Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17527 Virginia Avenue 21740 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White 3 X Widowed 4 Divorced Specify: Completed 1954-56 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ectrical Engineer Govt. Contractors Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Buellah Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Peter Lawyer - Son</u> <u>7527 Virginia Avenue, Hagerstown, Maryland 21740</u> 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory! 11/24/10 Hagerstown, Maryland Signature of Funeral Service Lice & e 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, disease or condition resulting in death) vitical Medical or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed vesse 1 attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ed by the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by tibrill-tion 1 Yes 2 No 3 Probably 4 Unknown peen oraplasia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 🗌 No em 2 1 Yes the Funeral Director; After this certific released filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be Hospital: Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital o within 24 hours aff To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2010 100625

Registrar

State

*

0

Registrar's Signature

Medi

tesers Thous

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Khol.2

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State AMEND#23a(b)perMD12/6/10,BMW,MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Matilda J. LOBRED 2010 3:44 AM M Medical November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Montgomery Bethesda Suburban Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 K Months Days Hours Min 96 Illinois Director 061-14-9293 1914 15 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🕅 No Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States Funeral 20817 7803 Radnor Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice Kander Walter Hammerslough 19a. Informant's Name/Relationship (Type, Print)
Thomas Lobred, Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8624 Nan Lee Drive, Springfield, VA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 X Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) The Temple Cemetery 12/03/10 Louisville, KY 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 401008 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of lying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ cardiac arrest disease or condition resulting in death) - Medical Due to (or as a consequence of): Examiner Tachyarrhythmia Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ie attending physiclan and for use as the burial-trans Examine Due to (or as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 4 Pregnant
9 Unknown Pregnant at time of death Month 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending ☐ Accident Investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 3 Christine Carto, DO H 67499 23/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

NOV 2 9 2010

44

3

O

20814

Christine Castro, D.O., 8600 Old Georgetown Road, Bethesda, MD

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Decembe Physician/ DORIS JEAN LUPTON Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner narles Plata Conter a 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral 1 - M 2 XF Months Days Hours Min. 2 Mggth, Pag 32 (Gountry) 78 240-60-2223 Director Usual Residence of Decedent or 28a-f show 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director CHARLES WHITE PLAINS MD. 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 20695 U.S.A. 7120 BENSVILLE ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married ş within 72 hours after Specify: WHITE If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importantt: If item 27 is marked other than 'a any injury or other traumatic event, the Meonee. Elementary/Seconday (0-12) NURSE REGISTERED HOSPITALS 12 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ORILLA ELLEN VIERS HUBBARD F. PAGE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7120 BENSVILLE RD. WHITE PLAINS, MD. 19a. Informant's Name/Relationship (Type, Print) 20695 JOHNNIE LUPTON-SPOUSE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State MD TETERAN'S the CEM. 12-15-10 CHELTENHAM, MD. Donation 5 Other (Specify) MQQ479 21. Signature of Juneral Service Licensee 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final altero schaeti Physician/ Coronar disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day Year Pregnant at time of death 1 ☐ Yes 2 ≥ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 21 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Arrol D5359L 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C45705~C5

DHMH 17 Rev 7/2009

Registrar

Date filed (Month, Day,

10-08271 Michael Earl Lich		Please Type of State berg State	of Maryland	d / Depa	artme		h and				201	0 39224
Diversion in		Registrar 1. Decedent's Name (First, Middle,Las	<u> </u>		unca	to or beati	<u>'</u>		2. Date of D	Reg. No eath	0.	3. Time of Death
Physicia Medical Examir	ıer	Michael Earl Lic 4a. Facility Name (if not institution, give	htenberg			Ab City T	our or l	ocation of De	Month October	29, 2	Year 010 4c. County of De	1527 hrs
	П	530 W. Howard Street	e street and numbe	er)			rstown	ocation of De	raui		Washington	
Funeral		Social Security Number 6. S	ex 7. A	Age (In yrs. I	ast birth	day) If Unde	r 1 Year	If Under 24	Hrs. 8. Date of	Birth (MI		Birthplace (State or
Director			M 2□F 5	7		Yrs. Months	Days	Hours	Feb.	13,	1953 Fo	reign CountryMaryland
'any	ł	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town o	r Location	-				-,-	10d. Inside City Limits
Maryland 28a-f show d at once.	ţō	Maryland Washingt	ton	Hag	erst	.own	Code			10a C	itizen of What C	1 X Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f abo injury or other traumatie event, the Medical Examiner must be notified at once.	Director	530 West Howard St	treet			2174				US.		
with	Pra	11. Marital Status	12. Was Decede		.S.	13. Was Deceder			(Specify Yes or erto Rican, etc.)	No-	14. Race - An White, etc	nerican Indian, Black,
death or ite	Funeral	1 Never Married 2 Married	1 Yes	2 X No					one raisen, etc.,			White
s after	<u>a</u>	Widowed 4 Divorced 15. Decedent's Education (Specify or	If Yes, Give Year or Dates:	ompleted)	16a D	1 Yes 2			of work done	116b	Specify: . Kind of Busine	
2 hour	ted	Elementary/Secondary (0-12)	College (1-4 c			uring most of wor						
036 thin 7 ne.	Completed	12th			Lab	orer				C	onstruc	tion
5-0 led wi Hygie other		17. Father's Name (First, Middle, Last)				<u> </u>			ame (First, Middle			
121 d be fi ental		Earl Lichtenberg 19a. Informant's Name/Relationship (T	Delet V		Taoh	Mailing Address			Seal) Gu			ato Zin Codo\
MD 21215-0036 nd 2 should be filed within 7 sith and Mental Hygiene. m 27 is marked other than aumatic event, the Medica	- 1	Diane Lichtenberg				0 West						
and 2 Jealth	-	20a. Method of Disposition			Place of	Disposition (Nam	ne of ceme		Date		c. Location - City	
Baltimore, permit. Pages I ar Department of Hee Important: If ite Injury or other trinjury or other tr		1 Burial 2 X Cremation 3		State		y or other place) erg Crem		, 11	/5/2010	Sm	ithsbur	g, Maryland
litin nit. P. artme sortan	ŀ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licen	see	DIII	CHD	22 Name and	Address o	of Eacility				,
Per Dept		Eric L. Brown, pe	r DVR			11601 Pe	nnsv.	lvania	1 Chape. Avenue	, на	gerstow	n, MD 21742
Physician /Medical		23a. Part I. Enter the disease, or comp failure. List only one cause on ea	lications that cause ach line. Combined Alc									Approximate Interval Between Onset and Death
Examiner			Due to (or as a cor			Intoxication (riyaroci	bdone, Ci	talopram, Di	liazeii		
	ē	il dily, loading to illinous	Due to (or as a cor	nsequence o	of):							
	틸	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a cor	nsequence o	·f)·					_		
executed an and al - transit	cal Examiner	d.										
		UNPENDED	#Z1,			10 12/13	3/10	TT ,#2 7	per ME		0,12/29/	
876 tificate ng phy as the	N.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outo		nancy 2	Fetal death	3	Ectopic pre	gnancy	1	Month	Day Year
Records, P.O. Box 68760, The law requires that the death certificate be icate has been signed by the attending physicipage 2 should be detached for use as the burn	Physician/Med	1 Yes 2 No 9 Unknown		at time of de	eath 5	Other (Spec	cify)					
by the ched	돌	Part II. Other significant conditions			esulting	in the underlying	cause giv	ren in Part I.	23e. Die	d tobacc	co use contribute	to the cause of death?
P.C es that igned be deta	ğ	- N		_					1 🗆 ነ	res 2	✓ No 3 F	robably 4 Unknown
rds, requir been s	Completed								24a. Wa	as an topsy		autopsy findings available to completion of cause of
eco he law ite has	E C						-		pe	rformed	? death	1?
ET T.	Be C	25. Was case referred to medical						of Death (Che				
Vita bysiel, this o	일	1 ✓ Yes 2 No		itient 2	,		J.,		rsing Home 5		dence 6 🗸 O	her: Scene
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the ra after death. 1 Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach		27. Manner of Death 1 Natural 5 Pending	28a. Date of I Oct 29, 201	njury y Year) 10	28b. Ti 1523	- 11 DAG 11		at Work? es 2 ✔ No	unknown	e how i	njury occurred	
r Atter	ficat	2 Accident Investigati	20a Diago of	Injury - At h	ome, far	rn, street, factory,	, office bui	ilding, etc.				Rural Route Number, City
Div	Certification	4 Homicide determine		/lulti-Fami	ily Apt.				530 W. Hov	vard St	treet, Hagersto	own, MD
Division of Vital Records, P.O. B vitin 24 hours after death. To the Hoppiral or Attending Physician: The law requires that the d within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Medical C	29a. Certifier (Check only one) 2 Medical Examine	ian: To the best of r:On the basis of e and manner state	xamination a	lge, deat and/or in	h occurred at the vestigation, in my	time, date opinion,	e and place, death occurre	and due to the ca ed at the time, da	ause(s) a ate and p	and manner as s place, and due to	stated. the cause(s)
To with	¥.	29b. Signature and title of certifier	and manner state			290	. License	number				Month, Day, Year)
		Mayanie In	e Smell				O.C.M	I.E.		00	ctober 30, 20)10
		30. Name and address of person who Margarita Korell MD. As	completed cause of ssistant Medic			111 Penn Str	eet, Ba	Itimore, M	D 21201			
	ate	31. Date filed (Month Pay Year)	2010 32. Regis	trar's Signati	ure Ø.	parke	,					
Regist	للتا		1		-							

10-09148 Lucas A Logsdon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ucas A Logsdor	n	State of Marylar 1- For State Registrar		artment of <i>rtificate of</i>		nd Mental		Reg. No. 20	10 3922
Physicia <u>/led</u> ical Examir		Decedent's Name (First, Middle,Last)					2. Date of De Month	Day Year	3. Time of Death 1949 hrs
IEUICAI EXAIIII	ici	LUCAS ANDREW LOGSDON 4a. Facility Name (if not institution, give street and num	ber)		4b. City, Town, o	r Location of De		er 28, 2010 4c. County of	
· /		Western Maryland Regional Medical C	enter		Cumberlan	ıd		Allegany	
Funeral Director			. Age (In yrs. I	-	If Under 1 Year Months Day		Min.		Birthplace (State or Foreign Country)
Director		233-57-1582 1 M 2 F Usual Residence of Decedent		Yrs	3 2	8	08/02	2/2010	MARYLAND
a ny		10a. State 10b. County	10c. City	, Town or Locati	on				10d. Inside City Limits
Maryland 28a-f show 1 at once.	ō	WV MINERAL	R	IDGELEY					1 Yes 2 XNo
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
ith the 23a o	al Di	R.R. 1, BOX 174–B 11. Marital Status 12. Was Deced	dent Ever in II	S 12 Wo	2675.		Specify Yes or N	U.S.A.	American Indian, Black,
eath w	Funeral	1 Never Married 2 Married Armed Ford			es, specify Cuba			White,	
after d	by Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Z A NO	1	Yes 2 X No	specify:		Specify:	WHITE
hours natur Exami		15. Decedent's Education (Specify only highest grade			t's Usual Occupa ost of working life			16b. Kind of Busi	ness/Industry
D36 thin 72 ne. than edical	Completed	Elementary/Secondary (0-12) College (1-4	(O (5+)	(NC	NE)			OM)	NE)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	e Cor	17. Father's Name (First, Middle, Last) BRANDON MICHAEL LOGSDOL	NT.					Maiden Surname) GILBRIDE	
212° Duld be Menta market cevent	To Be	19a. Informant's Name/Relationship (Type, Print)		19b, Mailing	Address (Stre			mber, City or Town,	State, Zip Code)
and 2 shou tealth and N tem 27 is n traumatic		BRANDON M. LOGSDON / F	ATHER				RT ASHBY	, WV 267	19
nore, MC ages 1 and 2 s nt of Health an t: If item 27 other traums		20a. Method of Disposition 1 WBurial 2 Cremation 3 Removal from		Place of Disposi crematory or oth	tion (Name of ce er place)	metery,	Date	20c. Location - C	City or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite Imjury or other tr		4 Donation 5 Other Specify:			CEMETE		2/03/10		ASHBY, WV
Baltimore, permit. Pages 1 a Department of He Important: If it injury or other t		21. Signature of Funeral Service Licensee	1111] ^{22. N}	ame and Addres	U	PCHURCH FORT AS		OME, INC. 26719
Physician		23a. Part I. Enter the disease, or complications that cau failure. List only one cause on each line.	sed the death.	. Do not enter th					Approximate Interval Between Onset and
∖/Medical ≟xaminer		Immediate Cause (Final disease a. Sudden			Syndro	пе		_	Death
		or condition resulting in death) Due to (or as a co	onsequence o	f):					
	<u>le</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	onsequence o	f):					
_ #	Examiner	(Disease or injury that initiated events resulting in death) Last	onsequence o	f):					
		d. X UNPENDED AMENDED	232 27	DOT MO	g913 3-	_2_11 ==	<u> </u>		
	Medical	IF FEMALE: 23c. If yes, out			g)13 3	-2-11 V	-	23d. Date of de	elivery
OX 6876(eath certificate eath certificate eath certificate for use as the b	an/M	23b. Was decedent pregnant in the nast 12 months?		2 Fet	al death 3	Ectopic preg	gnancy	Month	Day Year
Box 68760, c death certificate be the attending physic ad for use as the burner at the burner as the	Physici	1 Yes 2 No 9 Unknown 9 Unknown		ath 5 Oth	er (Specify)		****		
D. D. hat the ed by the etachec	by Ph	Part II. Other significant conditions contributing to d	eath but not re	esulting in the u	nderlying cause (given in Part I.			ite to the cause of death?
S, P.C. quires that en signed b						·	1Ye 24a. Was		Probably 4 Unknown
Cord law rec has be	Completed						auto	osy prid	or to completion of cause of ath?
tal Re		25. Was case referred to medical			26 Place	e of Death (Chec		2 No 1	Yes 2 No
/ital	o Be	examiner?	atient 2	ER/Outpatient		Othor:	sing Home 5	Residence 6	Other:
J of V	⊢ †	27. Manner of Death 28a. Date of (Month, Date)	Injury ay,Year)	28b. Time of In		ry at Work?	28d. Describe	how injury occurred	
ivision or Attendi after death. Director:	atio	2 Accident Investigation				Yes 2 No	000 1	Otract and Misselves	Dest Dest Newton City
Division of Vital Records, tal or Attending Physician: The law requints after death. and Director: After this certificate has been sted in by the funeral director, page 2 should the funeral director, page 2 should	Certification:	3 Suicide 6 Could not be determined (Specify)	of Injury - At no	ome, tarm, stree	t, factory, office b	building, etc.	or Town, S		or Rural Route Number, City
hou ner y fil		29a. Certifier 1 Certifying Physician: To the best of cone one 2 Medical Examiner: On the basis of cone one							
To the within 7 To the comple	Medical	and manner stat	ed.	200	29c. Licens				(Month, Day, Year)
		Color Satter 4/4	let-	180	O.C.	M.E.		November 29	9, 2010
		30. Name and address of person who completed cause			onn Cter-t D	Paltimor- **	D 21201		
Sta	310	Victor Weedn MD JD Assistant Medi	cal Examin strar's Signatu		enn Street, E	oaitimore, M			
Sta Registr	_	DEC 13 2010 /2000	Jo.	THE WALL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			For State Registrar	State	of Maryla	•	artment of F tificate of E		Mental Hy	giene Reg. No.	10	39226
П			1. Decedent's Name (First, Middle	, Last)					2. Date of De	eath	Vacu	3. Time of Death
	Physicia Medic		Nancy D.	Miller					Novemb	er 19, 2	010	6:52P ^M
J.	Examin	er	4a. Facility Name (if not institution, Hebrew Home of	_		rton		Location of Death	1	4c. County		omery
	Funeral Director	ď	5. Social Security Number 015–14–4076	6. Sex 1 ☐ M 2 X ☐ F	7. Age (In yrs. 91	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	8, Year 1919		place (State or Foreign Sachusetts
	d tow	_	Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Loc	eation				1.	Od. Inside City Limits
	arylan a-f sh fied a	Funeral Director		tgomery	100.0	•	nesda					1 ☑XYes 2 ☐ No
	or 28 e not	Dir	Maryland Mon 10e. Street and Number	Lydriely		100	10f. Zip Code			10g. Citizen of	What Cour	ntry?
:	s 23a uust b	era	8315 N. Brook	klane, Ap	t 805		20	814		Unit	ed St	cates
	death 'item nerm		11. Marital Status	Armed Fo			Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		e - Americ	
5	al", or	d by	1 ☐ Never Married 2 ☐ Marr 3X Widowed 4 ☐ Divorced	If Voc Gir		1	☐ Yes 2 🛭 No	Specify:		Specify		
9500-c	hours natur dical E	Completed	15. Deceder	nt's Education			ent's Usual Occup		l.t	16b. Kind of B	usiness In	dustry
7	nin 72 ne. han " e Mec	omp	Elementary/Seconday (0-12)	est grade completed College (*	1-4 or 5+)	life. Do	ind of work done of NOT use retired)	aunng most of wor	KING		1 0	
7	d with	l ou i	12 17. Father's Name (First, Middle, L	not)] Se	ecretary	10. Bánábarin blau	na (Finak Adiaballa	, Maiden Sumam		vernment
yland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Hygiene. Bris marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To B	· · · · · · · · · · · · · · · · · · ·	yden Da	ıy			Elizab			5)	
Mary	should and N is ma		19a. Informant's Name/Relationsh			1.7	g Address (Street a			-		
∑ ;	ind 2 s lealth m 27 her tra	0	Elizabeth A. M	iller/dau				lane Apt				yland 20814
ָם פר	ge 1 a nt of H t: If ite or ot		20a. Method of Disposition 1 Burial 2 Cremation		n State		natory`or other plac		Date	20c. Location	-	
Baltimol	nit. Pa artme ortani injury		4 Donation 5 Other (S	pecify)	Fir		ney Crem					Maryland
ñ	lmp any onc	Ų	Manuta R	Thomas	5 MOC)957 G	Name and Address Ding Home everly L.	Cremati Heckrot	on Serv te, P.A	ice P.O. . Clarks	Box ville	784 e, MD 21029
			23a. Part 1 Enter the disease, or shock, or heart failure. List of	complications that	caused the dea	ath. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
P	hysician/	N S	Immediate Cause (Final disease or condition	_a_E	nd stu	ge D	ement:	1				Onset and Death
d	Medical Examiner		resulting in death)	Due to	(or as a consec	quance of):						
3	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury	b. Due to	(or as a consec	quence of):						
1	care be executed physician and the burial-transit	Exa	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):						
3	re be e nysicia ne buri	edical		d								
100	ling ph	/Me	IF FEMALE:	22a Huan au	stooms of progr							
XOD T	ath ce attend for us	cian	23b. Was decedent pregnant in the past 12 months?	1 Live	itcome of pregr e Birth 2 ☐ Fe gnant at time of	tal death 3 🗌	Ectopic pregnanc Other (specify)	_y		1	te of deliventh	ery Day Year
0	the de	Physician/M	1 Yes 2 No 9 Unknown	g 🗌 Unk								
ב ו	s that gned b	by	Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	nderlying cause giv	en in Part I.				ne cause of death?
S	equire een si ould l	eted										bably 4 🗆 Unknown
ecords,	has b ge 2 st	Completed							24a. Was auto perfe	psy	Were auto prior to co death?	psy findings available mpletion of cause of
	in: The		25. Was case referred to medical			_	26 Pla	ace of Death (Che	1 🗌 Yes		1 🗌 Yes	2 No
VICAL	ysicia is cert direct	To Be	examiner? 1 ☐ Yes 2 💢 No	Hospital:	Inpatient 2	ER/Outpatien	Othe			dence 6 Othe	er (Specify)
5	ng rn fter th neral		27. Manner of Death 1 X Natural 5 □ Pendin	28a. Date (Mor	e of injury oth, Day, Year)	28b. Time of injury	28c. Injury work	/ at		how injury occurr		
וסוי	death. tor: A the fu	Certificate:	2 Accident Investig	gation	e of Injuny At h	nome form etre		Yes 2 No	005 L ti 4	Character and March	au - # Ot mai	Pouts Number
DIVISION OF	ral or A rs after al Direc ed in by		4 ☐ Homicide determ		ling, etc. (Speci		et, factory, office		City or To	Street and Number vn, State)	er or Hurai	Houte Number,
	to the hospital or Autending Prysician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 Medical E	Physician: To the lixaminer: On the ba Nurse Practioner:	sis of examination	on and/or invest	igation, in my opinio	on, death occurred	at the time, date	and place, and due	e to the ca	use(s) and manner stated.
, i	No unithin To the compl	2	29b. Signature and title of certifier		TO the best of f	., raiomouge, c	29c. License		and due to the	29d. Date signed		
			mina Je	whi			D06	64871		11-20	-20	lo
i	0		30. Name and address of person of Mina Fazli	who completed cau	se of death (Ite	m 23a) (Type, P	rint)	Rd	Rocker			
	Stat	e	31. Date filed (Month Pen Year)	2010 32.	egistrar's Sign	ature	ontrose	1-61	, water	- 4		
	Registra		IVUV A	J LUIU /4	CHELLEN	12. 14	arrow					i

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Month Year Dorothy Lura Melby /Medical November 28 2010 9:45 A 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Homewood Retirement Center Williamsport Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) June 21,1917 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 200 Months Days Hours Min. Yrs. Director 93 342-10-6984 Michigan Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State show 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f should be notified at Director 1 □Yes XXNo Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Avenue Funeral 21795 USA d other than "natural", or items event, the Medical Examination Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 <u>۾</u> 1 ☐Yes 2 No 3 Widowed 4 □ Divorced Specify White Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, In-IM once. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Morrison Emmett Finch Myrtle Blackburn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21742 Richard Melby-Son 18932 Orchard Terrace Road Hagerstown, Maryland altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 6 ☐ Other (Specify) Greenlawn Mem. Park Dec.2,2010 | Williamsport, Maryland 21. Signature of Funeral OSBOTTE AFUTTEFETTY Home, P.A. 425 S. Conococheague St.Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications hat caused the death. Do n. Lenter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus or each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of g physician and as the burial-transit or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical attending pt for use as th IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Day Year 5 Other (specify) P.O. been signed by the should be detached 1 □Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the orderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1 □Yes 2 director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: After this funeral din 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury ours after death.

neral Director; A
filled in by the ft r death. 1 ☐ Yes 2 ☐ No 3 Sulcide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) e and ac o completed cause of death (Item 23a) (Type

DHMH 17 Rev 1/2001

State Registrar Year

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryl		artment of F		d Mental Hy	7111	0 39228
			Negistrar Name (First, Middle, Last)			inicate of L	Jeani	2. Date of De	Reg. No.	
Н	Physicia Medic		Shirley 1	M. Murray					er 20, 20	3. Time of Death 11:40 P M
	Examir		4a. Facility Name (if not institution, give st			4b. City, Town, or	Location of De		4c. County of	
-	£		Casey House			F	Rockvil	le		ntgomery
	Funeral		5. Social Security Number 6. Sex	44.0 187 =	rs. last birthday)	If Under 1 Year Months Days	If Under 24 H			Birthplace (State or Foreign Country)
	Director		577-54-3526 1 Usual Residence of Decedent	7	3 Yrs.	Monard Bayo	Tiodis IV	Aug • 22	1937	Country) DC
	thd show	5	10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Aaryla 8a-f s tified	ect	Maryland Montgo	merv			Rockv	ille		1 🔀 Yes 2 □ No
	the l	٥	10e. Street and Number			10f. Zip Code	2100111	1	10g. Citizen of Wh	at Country?
	s 23%	Funeral Director	1355 Piccard Drive	Suite 100			20850		Unite	ed States
	deatl item ner n	Fui		2. Was Decedent Ever in Armed Forces?	U.S. 13. V	Vas Decedent of His Yes, specify Cuba	spanic Origin? n. Mexican. Pu	(Specify Yes or No- erto Rican, etc.)		American Indian,
36	after al", or xami	d by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give		☐ Yes 2 🔀 No		, , , , , , , , , , , , , , , , , , , ,	Specify:	White, etc. Black
Ö	nours latura ical E	Completed	15. Decedent's Educ	Year or Dates.	16a Decer	ent's Usual Occupa	ation			
215	n 72 l an "r Medi	dm	(Specify only highest grade Elementary/Seconday (0-12)		(Give I	kind of work done d NOT use retired)	uring most of v	vorking	16b. Kind of Busi	ness Industry
2	withi giene ner th	ပိ	12th	Obliege (1-4 of 3+)		Secret	ary		Go	vernment
nd	filed tal Hy doth	To Be	17. Father's Name (First, Middle, Last)	-			18. Mother's N	Name (First, Middle,	Maiden Surname)	
₹	uld be I Men narke natic	-		1d N. Cavar	augh			Beatri	ce Scott	
Nai	2 sho th and 7 is r		19a. Informant's Name/Relationship (Type	,				Rural Route Number		
ė,	and Healt		Anthony James Mur 20a. Method of Disposition		4602 b. Place of Dispos		shire A	Avenue NW	Washing	
nor	age 1 ent of it: If il		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery, crem	atory or other place) Noy	ember 26	20c. Location - Ci	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice			mony				er, Maryland
ä	lmp any onc	2	Dry M. C.	JON 110W	4M]			Stewart Fu bad NE Wa		
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the de	eath. Do not ente					Approximate
	Physician/	31 8	Immediate Cause (Final disease or condition	Sepsis						Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a cons	equence of):					
		-	Sequentially list conditions, b.	Right Leg		ne				
	ed sit	Ĭ,	if any, leading to immediate cause. Enter Orderning	Due to (or as a cons			7.4			
	xecut	Examiner	that initiated events c. resulting in death) Last	Severe Pe		L Vasurla	r Disea	ase		
09	death certificate be executed re attending physician and ed for use as the burial-transit	dical	d.							
376	ificate ig phy as the	Med	IF FEMALE:							
89 x	h cert tendir r use	an/	23b. Was decedent pregnant 23c	. If yes, outcome of pred 1 Live Birth 2 F		Ectopic pregnancy	,		23d. Date o	of delivery
Box	deat	Physician/Me	in the past 12 months? 1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4 ☐ Pregnant at time of ☐ Unknown		Other (specify)			Month	Day Year
P.O.	at the d by t		Part II. Other significant conditions contr	buting to death but not i	resulting in the ur	iderlying cause give	en in Part I	OO- Dida		
S, T	signe d be o	d b				aan, ng aasa gn	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			te to the cause of death?
ord	requ been shoul	lete								
Ö	e has	Completed						24a. Was a autops	sv prior	e autopsy findings available r to completion of cause of th?
<u> </u>	an: The tifficat tor, pa		25. Was case referred to medical		_	26 Plac	ce of Death (Ch	1 Ves	2 2 No 1 □	Yes 2 No
<u> </u>	nysici lis cer direc		examiner? 1 \(\sum \) Yes 2 \(\boldsymbol{X} \) No	pital: 1 Inpatient 2	☐ ER/Outpatient	Other			ence 6 X Other/S	Specify) Hospice
ō	ng Pt fter th ineral		27. Manner of Death 1 → Natural 5 → Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c, Injury : work?	at		w injury occurred	specify 1
<u>o</u>	tendi leath. tor: A the fu	<u>ii</u>	2 Accident Investigation 3 Suicide 6 Could not be		1		es 2 No		_	
Division of Vital Records,	or At after of Direct in by	Certificate:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		et, factory, office		28f. Location (St City or Town		r Rural Route Number,
2	spital ours eral l filled		29a. Certifier 1 X Certifying Physicia	un: To the heat of my kno	wledge doeth or	sourced at the time.	data and place	and durate the con-	- (-)	
	To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medical Examiner: only one) 3 Certifying Nurse P	On the basis of examinat	ion and/or investic	ration, in my opinion	 death occurre 	d at the time date an	d place and due to	the cause(s) and manner stated
	To th Withii To th		29b. Signature and title of certifier	10 110 1001 01	,əmeage, de	29c. License r			9d. Date signed (M	
			Balmol	~		D0060)634		November	
2	5	Ī	30. Name and address of person who com	pleted cause of death (Ite	em 23a) (Type, Pri				o.cmbcr	
6			Bindu Joseph, M.D. 31. Date filed (Month, Day, Year)	W. I		11 Road	Rockvi	lle, Mary	land 208	355
	State Registra		NOV3 0 2010	32. Registrar's Sig	ature					
			/**	77 77						

Amend #17, per Fh g910 12/21/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Physician Inez Burvee Mooney 26, 2010 8:50 A November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Crescent Cities Center Riverdale If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗷 F 85 Director 242-36-8762 05/02/1925 Brevard.N.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" any injury or other traumatic exercises. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 □ No Md. P.G. Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 U.S.A. 5004 Addison Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Black Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Manager Public Schools 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Allie Vonard Aiken Ina Orr ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Scriber/Daughter 1702 Pin Oak Parkway, Bowie, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 12/04/10 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland Lincoln Cem. Signature of Funeral Service Licensee Name and Address of Facility. Henry S. Washington & Sons Co., Inc. aus 4925 Burroughs Ave., N.E., Washington, D.C. 20019 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final **Physician** Bladder Lancer. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed use as the burial-trar and Due to (or as a consequence of) Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 □Yes 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mannef of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred **Division** 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐No 2 Accident 3 🗋 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058095 11/26/10 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 4409 Hardy East West Riverdale 31. Date filed (Month, Day Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 9:17p M Mendelsohn November Mark Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 20604 Gleaning Court Gaithersburg Montgomery 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 1 X M 2 🗆 F Hours Washington, DC **Director** 216-50-7323 61 Usual Residence of Decedent of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Gaithersburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20604 Gleaning Court 20882 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced Caucasian Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **5** + Photographer Photography Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Mendelsohn Greta Klein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20604 Gleaning Court, Gaithersburg, Maryland 20882 Rhonda Brodbeck - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 🕱 Burial 2 🗌 Cremation 3 🗌 Removal from State Parklawn Memorial Grdn 11/29/2010| Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Kowe 11800 New Hampshire Ave.. Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 3 ULWS shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ disease or condition resulting in death) <u>Amyotrophic Lateral Sclerosis</u> uears Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to the cause. Enter Underlying Cause (Disease or iinjury Due to for as a nonsecuence of attending physician and for use as the burial-tran To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Day Year 1 Yes 2 g 2 No 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) After this filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No X Natural Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Medical

State Registrar

29a Certifier

29b. Signature and title of certifier

Sean Dwyer,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

5454 Wisconsin Ave.,

💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D25818

#925, Checy Chase, Maryland 20815

29d, Date signed (Month, Day, Year) November 26, 2010

Amended Item 26 per Phy State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Virginia LaRue Miller 18, 2010 November 9:52 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 137 Union Bridge Road Carroll Union Bridge If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F 89 Yrs Director 213-12-7959 Sep 8, Maryland 1921 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Exercities must be additived at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Directo Taneytown 1 ☐Yes 2 No Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21787 5539 Taneytown Pike USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No IfYes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ white 3 ₩ Widowed 4 □ Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Dayhoff Rhoda Bowersox ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2540 Roop Road, Taneytown, MD 21787 Department of Health Important: If item 27 any injury or other transmission. Susan Devilbiss, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Keysville Union Cem. 11/27/2010 Keymar, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) + eale /Medical Due to (or as a cons - uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events could be seen to be seen the case of the cas Examiner Due to (or as a consequence of): law requires that the death certificate be executed and the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 1 Yes 21 No 9 Unknow 5 Other (specify) P.O. ed by the a detached f signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Ď Completed 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? has 24a, Was an certificate Ko c C ha 1 ☐Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Son's Other: 4 Nursing Home Thesidence 6 NOther (Specify) House 1∐ Yes 2⊠(No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation Natural 2 Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 □ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number WIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) einfte OR V. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

0-09301		Please Type or							
Sary Leslie Mov	wery	State of	Maryland		nent of Health ar	nd Mental Hy	giene	2010	39232
		Registrar		Certific	cate of Death			j. No.	O. Time of David
Physici Medical Exam		Decedent's Name (First, Middle,Last) Gary	Leslie	M	owery		2. Date of Death Month	Day Year	3. Time of Death 2129 hrs
nagical Exam	IIICI	4a. Facilify Name (if not institution, give s				r Location of Death	December :	4c. County of Death	
		17700 Family Lane	a cot and number	,	Old Town,			Allegany	
Funeral		Social Security Number	7. Ag	ge (In yrs. last b			8. Date of Birth	(MM/DD/YYYY) 9. Birt	thplace (State or
Director		213-78-9019 1 TM		53	Yrs. Months Day		Sep 14	Foreig	
-		Usual Residence of Decedent	201		113.		TOOP !	1, 1001	
any		10a, State 10b. County		10c. Cify, Tow	n or Location				10d. Inside City Limits
nd show	Ä	MD Frede	rick		Frederick				1 X Yes 2 No
Aaryland 28a-f show I at once.	Director	10e. Street and Number		·	10f. Zip Code		100	g. Citizen of What Cour	
72 hours after death with the Maryland n "matural", or items 23a or 28a-f she al Exminer must be notified at once		8204 Red Wing C	ourt		:	21701		US.	A
with response	Funeral		2. Was Deceden		13. Was Decedent of Hi			14. Race - Ameri	can Indian, Black,
death or ite	Ë	1 Never Married 2 Married	Armed Forces' Yes 2	No No	if Yes, specify Cuba	n, Mexican, Puerto F	(Ican, etc.)	White, etc.	to
after	by F		Dates:		1 Yes 2 No			Specify:	
hours	ed	15. Decedent's Education (Specify only I			Decedent's Usual Occupa during most of working life			16b. Kind of Business/li	ndustry
36 in 72 han '	plet	Elementary/Secondary (0-12)	College (1-4 or	´	Deleter			Daallava	0
With with her t	Completed	12 17. Father's Name (First, Middle, Last)			Printer	18.Mother's Name (First Middle Ma	Reglious	Org.
1215-0036 Id be filed within 72 hour fental Hygiene. narked other than "nat event, the Medical Execut.	Be C	Loyd Leslie Mo	werv					arrico) Mow	<i>ier</i> v
	To B	19a. Informant's Name/Relationship (Type Snerry Mowery		11	9b. Mailing Address (Stree 8204 Red V				
imore, MD 2 Pages 1 and 2 shou ment of Health and N tant: If item 27 is n or other traumatic	•	Snerry Mowery	VV	ife	8204 Red \	ving Cour	t ⊦re	derick	MD 21701
ore, ME ss 1 and 2 s of Health a If item 27		20a. Method of Disposition			of Disposition (Name of ce atory or other place)	emetery,	Date :	20c. Location - City or	Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other ti		1 Burial 2 Cremation 3 4 Other Specify:	Removal from St	ale	n Cemetery		12/7/2010	Oldtown	MD
altii mit.] partm porta ury o		21. Signature of Funeral Service Licensee			22. Name and Address	s of Facility		O late Will	5
E F P R W		VIMAII/A				oelli Funeral H /irginia Avenu		and, MD 21502	
Physician		23a. Part I Enter the disease, or complical failure. List only one cause on each	tions that caused	I the death, Do r	not enter the mode of dying	, such as cardiac or i	espiratory arres	t, shock, or heart	Approximate Interval Between Onset and
∖/Medical ≛xaminer	1		nerosclerotic	Cardiovasc	ular Disease				Death
2/10/11/11/01		or condition resulting in death)	to (or as a cons	equence of):					
	5	Sequentially list conditions, if any, leading to immediate Due	to (or as a cons	equence of):				-	
	Ė	cause. Enter Underlying Gause (Disease or injury that initiated							
ed sit	Examine	events resulting in death) Last Due	to (or as a cons	equence of):					
executed an and ial - transit	cal	d	MENDED						
O, e be e ysicia burial			MENDED						
tox 68760, eath certificate be est attending physicia for use as the buria	sician/Med	23b. Was decedent pregnant in the	23c. If yes, outcor		Fetal death 3	Ectopic pregnance	cv	23d. Date of delivery Month D	ay Year
X 6	icia	past 12 months?	Pregnant at	time of doath	5 Other (Specify)				,
BO) e deatl the att	Phys	i	Unknown						
s, P.O. ires that the signed by the detacher	J P	Part II. Other significant conditions co	ntributing to deat	h but not resultir	ng in the underlying cause of	given in Part I.		acco use contribute to t	
S, F uires t n sign		Diabetes Mellitus						2 No 3 Proba	
ords w requir	Completed						24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
(ecc	티		-		·		perform 1 ✓ Yes 2		2 No
Vital Reco ysician: The law his certificate has director, page 2 s	BeC	25. Was case referred to medical			26.Place	e of Death (Check on			
Vita hysicia this ca	0	examiner? 1 ✓ Yes 2 No	oital: 1 Inpatie	ent 2 ER/C	Outpatient 3 DOA	Other Nursing	Home 5 Re	esidence 6 🗸 Other:	Scene
n of ing Ph After 1 funeral	빌	27. Manner of Death	28a. Date of Inju (Month, Day,Y	iry 28b.	Time of Injury 28c. Inju	ry at Work? 2	8d. Describe how	w injury occurred	
icath.	aţi	1 Natural 5 Pending 2 Accident Investigation	,,		1□,	Yes 2 No			
Vision At the differ distribited in by	ij	3 Suicide 6 Could not be	28e. Place of In	jury - At home, f	arm, street, factory, office b	ouilding, etc. 2		eet and Number or Rur	al Route Number, City
Divisipital or At ours after d teral Direct filled in by	Certification:	4 Homicide determined	(Specify)				or Town, Stat		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Sal ((oncon only		-	eath occurred at the time, da		,		
To the Hos within 24 h To the Fun completely	Medical	an	the basis of examed manner stated.	mination and/or	investigation, in my opinion				
	Σ	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mon.	
		(atoker	\mathcal{U})		O.C.I	M.E.		December 4, 201	υ
	İ	30. Name and address of person who com		,	10 0 -				
			t Medical Exa		1 Penn Street, Baltir	nore, MD 2120	l 		
St	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Miller 0026 Wilda O Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Cumberland Allegany Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Min. Jun 22 1 □ M 2 □**y**F Director 218-24-7818 83 Usual Residence of Decedent or 28a-f shov notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shor 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Allegany Cresaptown 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a 14611 Winchester Road 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates Specify. Completed 3 KWidowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Thrift Store manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Melvin B. Riffey, Sr. Edith S. (Strawderman) Riffey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 14611 Winchester Road Cresaptown Nancy Miller daughte MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place
Sunset Memorial Park 1 X Burial 2 Cremation 3 Removal from State Cumberland MD 4 Donation 5 Other (Specify) gnature of Funeral Service Licenses 22. Name and Address of Facility Page 12. Name and Page 12. Name 12. N 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner sequence of) signed by the attending physician and be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Pregnant at time of death Unknown Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 🗌 Yes 2 🔀 No Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, after death.

Director: After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3/4

DHMH 17 Rev 7/2009

State Registrar Nuvammad 31. Date filed (Month, Day, Year, 10-09269 Mark Delano Martin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

)	0	REPLANTA A	0	3	9	2	3	-
	0	i	5.7	V	-2	Even	V	٠

		1- For State Registrar	tate of Marylane		cate of			ita. Hygioni	Reg. N	No.	
Physici	an/	Decedent's Name (First, Middentification)	dle,Last)					2. Date of Month	of Death Da	ıy Year	3. Time of Death
Medical Exami	ner	Mark Delano 4a. Facility Name (if not institution	Martin	r)		b. City, Town, o	r Location /		mber 2,	2010 4c. County of D	1850 hrs
		5005 Western Pike	on, give sireet and humbe	1)	7	Hancock	Location	OI Death		Washington	
Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last b	irthday)	If Under 1 Ye	ar If Unde	er 24Hrs. 8. Date	of Birth (N	 M/DD/YYYY 9.	Birthplace (State or Foreign
Director		192-32-9916	1XM 2 F		73 yrs.	Months Day	ys Hours	Min. 10/	13/19	37	PA
		Usual Residence of Decedent		T							
w any		10a. State 10b. County		10c. City, Tow		on					10d. Inside City Limits 1 Yes 2 No
yland P-f sho	ğ	MD Wash	ington	Hanco	ск	10f. Zip Code			100.0	Citizen of What (
ne Maryland or 28a-f show lifed at once.	Director	5005 Western	Pike			21750				SA	
with th		11. Marital Status	12. Was Deceder	nt Ever in U.S.		Decedent of H		gin? (Specify Yes	or No-		merican Indian, Black,
death rritem nust b	Funeral	1 Never Married 2 X N	Armed Forces	s? 2 X No	If Ye	s, specify Cuba	n, Mexican,	, Puerto Rican, et	C.)	White, et	С.
after	D P		vorced If Yes, Give Year or Dates:			Yes 2 X No				Specify:	White
hours natur		15. Decedent's Education (Spe Elementary/Secondary (0-12)				s Usual Occupa st of working life		kind of work done use retired)	168	o. Kind of Busine	ss/Industry
36 hin 72 e. than	Completed	11	College (140		ssemb	1er			Pa	arts Rem	nanufacture
5-00 ed wit lygien other	5	17. Father's Name (First, Middle	, Last)				18.Mother	's Name (First, Mi	ddle, Maid	en Surname)	
121 t be fill ental F rrked	Be	Roy R. Mart						bie Funk			
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Stant: If item 27 is marked other than "natural", or items 23a or 28a-f shoor or other traumatic event, the Medical Examiner must be notified at once.	٩	19a. Informant's Name/Relations			_	•		nber or Rural Rou			tate, Zip Code)
and 2 lealth tem 2 traum	ŀ	Carol V. Marti 20a. Method of Disposition	n/wire	20b. Place	of Disposit	ion (Name of ce		Hancock Date	20 PM (.)	C. Location - City	or Town, State
OFF ages 1 nt of F t: If i		1 X Burial 2 Cremation		late	atory or other	erplace) .idge Ce		12/06/20	10 N	odmoro	DΛ
Baltimore, MD permit. Pages 1 and 2 she Department of Health and Important: If item 27 is injury or other trauman	-	4 Donation 5 Other S 21. Signature of Funeral Service	pecify: Licensee	Titeas		ime and Addres				ain Stre	
E Pe W	1	Kelne		M00260	Gro	ve Fune	ral H	lome, P.A.	Hanc	ock,MD 2	21750-0368
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause		d the death. Do i	not enter the	e mode of dying	, such as ca	ardiac or respirato	ry arrest, s	shock, or heart	Approximate Interval Between Onset and
Examiner	ı	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a con:								Death
,		Sequentially list conditions,	b.	sequence or,							
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a con:	sequence of):							
-	Examine	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of):							
760, icate be executed physician and the burial - transit			d								
60, ate be ex shysician re burial	Medical	UNPENDED	AMENDED								
876 ifficate ng phy ss the t		IF FEMALE: 3b. Was decedent pregnant in t	23c. If yes, outco	ome of pregnancy	477	l death 3	Ectopic	pregnancy	2	23d. Date of deliver Month	very Day Year
Box 687: death certific	icia	past 12 months? 1 Yes 2 No 9 Uni		t time of death	=	er (Specify)			8		
). BC the deg	Physician/	Part II. Other significant condit	9 Olikilowii	th but not resulti	na in the un	derlying cause (given in Par	rt I 23e.	Did tobaco	co use contribute	to the cause of death?
P.O.	ē	art ii. Outor organioant contait	contributing to dea	() par not room	ng m alo un	donying dada	givoiriiri	1			robably 4 Unknown
ords, w require s been si should b	Completed							24a.	Was an		autopsy findings available
e law c has l	립							—	autopsy performed Yes 2	? death	
Vital Rec ysician: The his certificate director, page		25. Was case referred to medica	ıl			26.Place	e of Death (Check only one)	165 2	No 1 🗸	Yes 2 No
Vita	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpati	ent 2 ER/0	Outpatient	3 DOA	Other4	Nursing Home	5 Resi	dence 6 🗸 Ot	her: Scene
J Of Jing Ph		27. Manner of Death 1 Natural 5 Percentage	28a. Date of Inj (Month, Day Dec 2, 2010		Time of Inj 39 hrs		iry at Work?	Padastr		njury occurred ck by car	
Sion Attend r death. ector: by the f	catio	_ J Fend	stigation	njury - At home,			Yes 2		tion /Stront	and Number or	Rural Route Number, City
Division of Vital Records, tal or Attending Physician: The law requir rs after death. *I Director: After this certificate has been sited in by the finneral director, page 2 should	Certification	dete	Id not be rmined (Specify) Lo		iaitii, street	lactory, office t	ounding, etc	or To	wn, State)	e, Hancock, M	
Hospit 14 hour Funer		202 Certifier	hysician: To the best of n		eath occurre	ed at the time, de	ate and plac				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical		miner:On the basis of exa		investigatio	n, in my opinior	n, death occ	curred at the time,	date and p	place, and due to	the cause(s)
H 3 H 5	ž	29b. Signature and title of certific		1.		29c. Licens			1		Month, Day, Year)
		alun	VI	1 Fly		O.C.	M.E.		D€	ecember 3, 2	010
		30. Name and address of person Zabi∪llah Ali, M.D.	who completed cause of Assistant Medical E			Street Rolf	imore M	ID 21201			
St.	ate	31. Date filed (Month, Day Year)	32. Regis			- Circot, Dail				-	
Regist	_	DEC 13 2010	Deven B.	gare							
DHMH 17 Pay 1/20	04				DICINIAL					DOME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 2010 04150 Belle ecempo /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. to November | 15,1913 **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 M 2X F 214-09-2374 Yrs 97 Marvland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.

nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 ☐ No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 11 West Baltimore Street 21740 Funeral .S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify: Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education event, the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary/Salesperson Shoe Store 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maurice McKinsey Hiram Blanche Belle Wolfe ပ traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau
once. 5601-D. Devonshire Place, Frederick, Md. 21703 Judith L. Harshman Niece 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Cemetery 12-09-10 |Smithsburg, Maryland 22. Name and Address of Facility Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21. Signature of Funeral Service Licensee R. heel Brad 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Periforitis **Physician** disease or condition resulting in death) //Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed and I-tran Due to (or as a consequence of): physician ar Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day ō Pregnant at time of death 5 Other (specify) 2 1000 9 Unknown the 9 Unknown signed by t ld be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? page 2 LM6 certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 🗆 No 1 🗌 Yes 2 ER/Outpatient 3 DOA မ this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation After Injury s after dea... al Director: After 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pletely filled in by determined 4 🗌 Homicide 24 hours a the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. within 2 To the I

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

lian

29c. License number

29d. Date signed (Month, Day, Year) December 04, 2010

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November Dolores I. Norvel1 9:48 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Prince George's Examiner 4b. City, Town, or Location of Death Regional Hospita dure! 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 □ M 2 😾 F 163-24-5832 80 3^M28-1930 Pennsylvania **Director** Yrs. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County Director 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Prince George's Mt. Rainier Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4600 30th Street Apartment #3 20712 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ဂ္ Thomas P. Cology Anna Julia Karnock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Farida Sattaur (Personal Rep)</u> 4704 Arabian Lane Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 11/28/2010 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee 3401 Bladensburg Rd. Brentwood, MD 20722 hompso Juhait 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury that initiated events resulting in death) Last signed by the attending physician and dbe detached for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Diabetes Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this eral Director: After the filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 \square Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

10

State Registrar Regional

Dusen

20107

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10-09249 Sharyse Victoria Napue Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

_	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	State of Maryland	/ Department of He	ealth and Me	ental Hygiene

1e. 2	1		Ω	2	9	2	3	7
has		J	_	10	1	5	\cup	1

,		1- For State Certificate of Death Registrar	Reg	g. No	00201
Physici	an/	Decedent's Name (First, Middle,Last)	2. Date of Death Month	Dav Year	3. Time of Death 2325 hrs
Medical Exami	ner	SHARUSE VICTORIA NAPUE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea	December	1, 2010 4c. County of Deat	
		Laurel Regional Hospital Laurel	au i	Prince Georg	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H	lrs, 8. Date of Birth		rthplace (State or Foreign
Director		523-69-7611 1 M 2XF 2 Yrs. Months Days Hours M	102/07	1) 1989 (0	LORADO
any	'n	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
und show		MD PRINCE GEORGES LAUREL			1 X Yes 2 No
Maryland 28a-f sho d at once,	Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Cou	intry?
th the Maryland 23a or 28a-f sho notified at once,	直	89.06 Ascor LN #21 20708 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (1)		USA	
0036 within 72 hours after death with the Maryland jene. ner than "natural", nr items 23a or 28a-f she Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puer		14. Race - Amer White, etc.	rican Indian, Black,
fter de '', nr		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: BL4	ACK
ours ad atural Kamin	d b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind o during most of working life. DO NOT use re		16b. Kind of Business	Industry
5-0036 led within 72 hou Hygiene. other than "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		20	
withii withii Med The	E	12 2 FOOD SERVICE REP. 17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (Eiret Middle Ma	YRIVE	17 È
21215-0036 puld be filed within 7 Mental Hygiene. marked other than ic event, the Medical	Be C				×=0
2121 ould be fi Mental marked		STANLEY VICTOR NAPUE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of			
my MD and 2 she lealth and tem 27 is traumati		THERESA NAPUE - MOTHER 8906 ASCOT LN 21 20a. Method of Disposition (Name of cemetery,	LAUREL	MD 207	08
nore, MI ages 1 and 2; nt of Health a nt: If item 27 other traum	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
Page Page ment c		4 Donation 5 Other Specify: WASHINGTON NATIONAL 12	19/2010	SUTTLAND	, Mb
Baltimore, permit. Pages 1 as Department of He Important: If ite injury or other tr		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	CAPITOL	MORTUA	RJ
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval
Medical		failure. List o'Aly one cause on each line. Immediate Cause (Final disease a. Complications Of Congenital Heart I	dicasca		Between Onset and Death
<i>E</i> xaminer		or condition resulting in death) Due to (or as a consequence of):)15ease		
		Sequentially list conditions, b.			-
	흘	if any, leading to immediate Due to (or as a consequence of):			1
ig da	Medical Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
760, cate be executed physician and the burial - transit		d. MENDED 23a,27 per me g911 1-28-11 v	rt		
760, ficate be e: g physiciar the burial		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy	nannu.	23d. Date of deliver	
Box 687 c death certific the attending p	ciar	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	nancy	Month	Day Year
BOy e death the att	Physician/	1 Yes 2 No 9 V Unknown 9 Unknown			
P.O. Box 687: st that the death certification greed by the attending edetached for use as 1	acco use contribute to	the cause of death? bably 4 Unknown			
IS, P.C quires that en signed ald be deta	Completed by		24a. Was an		atopsy findings available
cords, law requir has been s	ed t		autopsy perform	prior to	completion of cause of
tal Rec	Š		1 ✓ Yes 2	No 1 ✓ Yo	es 2 No
/ital F ysician: his certifi director,	Be	25. Was case referred to medical examiner? 4. ■ Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DDA Other4 Nurs		esidence 6 Othe	r
n of Vir ing Physic After this funeral dir	5	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe ho		
OD (endin sath. or: A	흘	1 X Natural 5 Pending 1 Yes 2 No			
Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been seled in by the funeral director, page 2 should!	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Str or Town, Sta		ıral Route Number, City
Divis Hospital or A 24 hours after Funeral Dire tely filled in b	2	4 Homicide determined (Specify) 29a. Certifier 4 Continue Developer Technology (Specify)			
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Medical	(Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred			
	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	nth, Day, Year)
1-PEND		Theodore Mr. K. of FR. M.) O.C.M.E. OC	OME	December 3, 20	10
		30. Name and address of person who completed cause of death (Item 23a)	MD 04001		
		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimo 31. Date filed (Month, Day, Year) 32. Registrar's Signature	re, MD 21201	·	
St Regist					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ November 18, 2010 Dorothy N. Orem 9:54 a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Taneytown 5789 Conover Road Carroll 5. Social Security Number If Under 7. Age (In vrs. last birthday) Year If Under 24 Hrs. 8. Date of Rinth 9. Birthplace (State or Foreign **Funeral** Month: Feb 8, 1921 89 214-12-1930 Mary land Director Usual Residence of Decedent show 10a. State 10b. County with the Maryland event, the Medical Examiner must be notified at Director 10c. City. Town or Location 10d. Inside City Limits 28a-f Carroll Taneytown Maryland 1 Tes 2 X No , TO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21787 23a 5789 Conover Road USA items 2 filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ō Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes Give "natural", 3 X Widowed 4 ☐ Divorced Specify: white Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than life. DO NOT use retired) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic access the contract of the contr Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ု့ဝ John Edward Hands Edna North 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5789 Conover Road, Taneytown, MD 21787 Helen E. Forquer, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place d Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11/23/2010 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial ture of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate k, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Syl Medical resulting in death) Due to (or as a conse unce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Yes Unknown been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 hnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? this certificate 1 Yes 2 LNd Yes 2 1 25. Was case referred to medical director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural iniury 5 Pending work?
1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: ocmpleted filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 52035 2010 Nov WIL WESTMIUSTER 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MÓ

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month

Stoner

32. Registrar's Signature

MACKO

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 39239 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 3:26 P November <u>Kelby Oldham Packett</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charles Tadcaster Circle Waldorf Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sountry)
Maryland Months Days Hours Min Director 54 Yrs 212-72-3662 December Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo XX Yes 2 ☐ No Waldorf <u>Maryland</u> Charles 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20602 41 Tadcaster Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 M Married Completed by 1 ☐ Yes 2 X No Specify Specify: 3 Divorced 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12th. <u>Security Installer</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ann Louise Frampton Packett <u>Sedrick Oldham</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tadcaster Circle, Waldorf, Maryland 20602 <u>Cvnthia Packett/ Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) <u>Maryland Vets'</u> Dec. 2, 2010Cheltenham, MD. Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home May G0 3035 Old Washington Rd. Waldorf, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between MOVENINE! Immediate Cause (Final disease or condition resulting in death) UMOR & Onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 2 [Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No 2 n 24 hours after death. ne Funeral Director: After this or pleted filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29b. Signature and title of cert

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

of person who completed cause of death (Item 23a) (I

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 72 20 2X O Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** (ranna 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth **Funeral** 77 1000th, Pay, Year 33 COMNY. 049-24-6490 1 □ M 2 💢 F **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the <u>Medical Examiner must be notified at once.</u> 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director 1 🗆 Yes 2 No LA PLATA MD. CHARLES 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral 20646 U.S.A. 9825 PENNS HILL ROAD 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 XNo Specify: If Yes. Give 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) AVON SALES REPRESENTATIVE AVON COSMETICS 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MADELINE CARKIN ပ္ DANIEL SPELLMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9825 PENNS HILL RD. LA PLATA, MD. 20646 EMANUEL PETRELLA-SPOUSE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State STEMARY CEMETERY 1 XBurial 2 Cremation 3 Removal from State 12-9-10 NEWPORT, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Ineral Service Licenses №00479 23a. Part 1. Enter the disease, or complications that caused the death. Do not Approximate Interval Between shock, or heart failure. List only one cause on each line. nd Death Immediate Cause (Final disease or condition Mator Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director. After this certificate has been signed by the attending physician and anding physician and use as the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year has been signed by the atte je 2 should be detached for 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 X director, page 2 X No Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 🗌 No ဂ္ 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) filled in by the funeral 27, Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident iniury work? 5 Pending 12/04/2010 15:40M Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or 4 Homicide determined building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and plane, and due to the cause(s) and manner as stated within 2 To the I VIIIV VIIIC 29b. Signature and title leted cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December РМ Daniel Clark Poore, Sr 2010 1950 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Harford Memorial Hospital Havre de Grace Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 X M 2 - F Davs Hours $NOV^{Month, Day,}$ 1942 Maryland Director 68 218-40-7722 Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director 1 Yes 2 X No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20 Doe Drive 21921 United States or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian traumatic event, the Medical Examiner Armed Forces? 1962.

1 X Yes 2 No 1965

If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No "natural", Specify: 3 Widowed 4 X Divorced White Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) and Mental Hygiene. Is marked other than College (1-4 or 5+) Owner/Operator Material Hauler Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Poore Edith Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Daniel C. Poore, Jr./Son 1005 Warburton Road, Elkton, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 1 A Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Elkton Cemetery Cemetery 9, 2010 Elkton, MD

22. Name and Address of Facility Ficks Home for Funerals, F.A. 21. Signature of Funeral Service Licenses 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ cell disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine burial-trans consequence of): attending physician I for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for to make the funeral director, page 2. in the past 12 months?

1 Yes 2 No Month Year 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 힏 1 Yes Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death Certificate: 28a. Date of injury 28h Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Settifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title & 29c. License number 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 3 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month CAROL 9:01 PM ANN PAYNE Medical December 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Hours 1 □ M 2 🔯 F 2/20/1947 Mary Land 62 **Director** 219-52-1216 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Frederick Frederick ö 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 2508 Shelley Circle, Unit 2D <u> 21702</u> <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "natural", or 1 Never Married 2 X Married 1 Yes 2 No
If Yes, Give
Year or Dates. Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 🗆 Widowed 4 🗆 Divorced Specify: white the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 6 <u>own ho</u>me homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Unknown Rosemarv Hiltner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Debra Fronzaglio / daughter</u> <u> 2508 Shellev Circle. Unit 2D</u> Frederick. MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Union Chapel Cemetery 12/09/2010 Libertytown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford Funeral Home Signature of Funeral Service Licensee Japulen 12re Church St. Frederick. MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Oncer and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Examiner day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transit or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending p d be detached for use as IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Live Fetal 35...
Pregnant at time of death in the past 12 month 1 Yes 2 No 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown page 2 should peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform hours after death. Ineral Director: After this certificate 1 ☐ Yes 2 ☐ No 2 No Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 No Accident Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of dea (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Regisar's State 2010 13 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2010 29 11:45p M William Raymond Rose Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 79 Curry Avenue Ceci1 Conowingo 8. Date of Birth (Month, Day, May 19 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 X M 2 □ F 66 Yrs. May Director 562-58-3540 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show 1 ☐ Yes 2 X No Funeral Director MD Ceci1 Conowingo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 79 Curry Avenue 21918 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □Xes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural" Completed 7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Systems Analyst Computers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Joseph Rose Henrietta Alves 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Rose/ wife Curry Avenue Conowingo, MD 21918 other t t of Healt : If item? y or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 Removal from State Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) R.T. Foard Funeral Home, P.A. Rising Sun, MD 21. Signature eral Service License Name and Address of Facility .I. Foard Funeral Home, P.A. II S. Queen St. Rising Sun, MD 21911 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician years Due to (or as a conse uence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ospital or Attending Physician: The law requires that the death certificate be executed hours after death.

uneral Director: After this certificate has been signed by the attending physician and ly filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □No 1 ∐Yes 2 🗷 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 \(\to \) Nursing Home 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Hesidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

completely 8+IVA

> State Registrar

29b. Signature and title of certifier

Va

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 11/25/10 9:24 Ам Elizabeth Rogovsky Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4227 29th Street Prince George's Mount Rainier If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) 11/22/1954 9. Birthplace (State or Foreign Country) Washington, DC Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🎛 F Director 56 216-68-0325 Usual Residence of Decedent show at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl 1 X Yes 2 No Prince George's Mount Rainier 10e. Street and Number 10f, Zip Code 5 10g. Citizen of What Country? "natural", or items 23a o Funeral 4227 29th Street 20712 Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Real Estate Investor Real Estate alth and Mental Hygie
27 is marked other
r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Samuel Rogovsky Helen Kocur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 7925 Georgetown Pike, McLean, VA Teresa Rogovsky / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1
Burial 2
Cremation 3
Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 11/30/10 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Part 1. Ent. the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Metastatic Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exam signed by the attending physician and I be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🔀 No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? spital or Attending Physician: The tours after death.

eral Director: After this certificate I filled in by the funeral director, page 2 🗆 No 2 🛛 N 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 🔀 No မ 1 Tes 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No X Natural injury 5 Pending M Investigation Accident

Division of Vital Records, e Hospital of 24 hours a

State Registrar

Ikechi Frederick Okwara, 12200 Annapolis Road, Suite #316, Glenn Dale, MD 20769 31. Date filed (Month, Day, Year)

s of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

determined

Suicide

4 Homicide

only one 29b. Signature and

Medical

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D43351

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

11/29/2010

City or Town, State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER Physician/ LOBERI Year 4 : 40 PM RANKIN 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death ADVENTISI HOSPO TIM KI ASHINGTON PARK MUNTGOMERS AKOMA Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country)
 H T **Funeral** 1 X M 2 □ F Months Days Hours Min. 578-84-219 53 08 Month 4 94 1 99 5 7 Director Usual Residence of Decedent ıral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DC Washington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2622 Jasper St. 20020 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc.
Black δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify 3 Divorced 4 X Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Carpenter Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Johnine Ellis 2 Wilbert C. Rankin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 2622 Jasper St. SE, Wash. DC 20020 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Johnine Rankin-Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Riverdale Park Cr 12-02-2010 4 Donation 5 Other (Specify) Riverdale, MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility DL McLaughlin Funeral 2019 MLK Jr Ave SE, Wash. DC 20020 21a, Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ ADVANCED CENTRAL NERVOUS SYSTEM LYMPHOM disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Secure daily list nor ditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery ☐ Live Birth 2 ☐ Fetal doc... ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No signed by the at d be detached for g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Y Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed?

1 Yes 2 No certificate 1 Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 1 🗌 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director; A Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) 006905 NOVEMBER 27 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARROLL AVENUE 7 600 TAKOMA PARK

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 4. 2013 November BARBARA MARIE RIGGS 1825PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Grove Adventist Hosp. to Montgomer 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Hours Min 02/21/1934 MD (MD) 217-30-0712 **Director** 76 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director Gaithersburg ĬΫD 1X Yes 2 ☐ No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20877 USA 9 Chestnut Street, #309 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. Montgomery County life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Morse Reva Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 458 Girard Street, #T2, Gaithersburg, MD 20877 Matthew Lee Riggs - son Baltimore, Department of Hea Important: If item 20a. Method of Disposition
1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from St 20b. Place of Disposition (Name of cemeter) crematory or other Date 20c. Location - City or Town, State crematory or other place, Cremation Svc: 11/29/10 4 ☐ Donation 5 ☐ Other (Specify) Hanover, MD Signatur Funeral Service Licen 22. Name and Address of Facility Snowden Funeral Home any ingi 246 N. Washington St, Rockville, MD 2085-23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one tions that caused the deat Do not enter the mode of dying, such as cardiac or respiratory arrest, nterval Betweer Immediate Cause (Final Onset and Death Ph_sician/ Traumatic Intracranial disease or condition resulting in death) 2mont Non Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year Yes _ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has tuneral director, page 2: autopsy performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 \(\triangle \) Nursing Home 5 \(\triangle \) Residence 6 \(\triangle \) Other (Specify) 1 ☐ Yes 2 🗷 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending iniury work? 1 ☐ Yes 2 ☐ No death. 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deatle Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 the only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 20070144 November 24,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 medical Ctr. Dr. Rockville, MD mo Michael 20850 31. Date filed (Month, Day, Year)

State

Registrar

29

22810

124

		·	Please	Type or Prin State of Ma	ryland / De	epartment of	Health and I		/ 1 1	ble.	39247
	Physic		Registrar 1. Decedent's Name (First, Middle, La	_{st)} nie Elizab		Certificate of	Death	2. Date of Dea Month December	_	2010	3. Time of Death 0200 AM
	/Medi Exami		4a. Facility Name (If not institution, given Elkton Care and	e street and number)			or Location of Death	th 4c. County		ty of Death	
	Funeral Director		5. Social Security Number 216-20-3160 Usual Residence of Decedent	6ex I□M 2\XF 7. Age 9	(In yrs. last birtho	Months Dave		8. Date of Birtl (Month, Day OCT 10,	7, Ye <i>ar)</i> 1914	9. Birthpla Count Mar	ace (State or Foreigry) Yland
re, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it as Medical Experiment be notified at	To Be Completed by Funeral Director	Maryland Ceci. 10e. Street and Number 223 3rd Street 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last Cecil Reading 19a. Informant's Name/Relationship (Rudolph J. Readi 20a. Method of Disposition	12. Was Decedent E Armed Forces? 1	Chesa Ver in U.S. 16a. D 17b. M 223	If Yes, specify Cuban, Mexican, Puert 1			Unit 14. Rac Black Specify 16b. Kind of Bo Wire Maiden Surnan	v or Town, State, Zip Code)	
Baltimore,	permit. Pages 1 and 2 bearing by Machine Department of Health Important: if item 27 any lijury or other tr. 9008.		1 Burial 2 Cremation 3 4 Donation 5 Other (Specification of Company of C	plications that caused one cause on each line a. OLD CE Due to (or as a	the death. Do not	22. Name and Add 103 W. enter the mode of dy	ress of Facility Hi Stockton	Street,	for Fu Elkton	neral , MD	
Division of Vital Records, P.O or Attending Physician: The law requires that the	• law requires that the death certificate be executed has been signed by the attending physician and e 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (or as a d	2 Petal death time of death	3 □ Ectopic pregnar 5 □ Other (specify)		1 □ Y 24a. Was a	bacco use contes 2 No	ribute to the	y Day Year e cause of death? ably 4 □ Unknown sy findings available
	ital or Attending Physician: The Its after death. 'al Director: After this certificate h led in by the funeral director, page	Certification: To Be Com	25. Was case referred to medical examiner? 1	28a. Date of Injur (Month, Day)	(Year) Inju	ie of 28c. Inj	ury at ork? □Yes 2□No	perför 1 □ Yes	ence 6 Oth	death? 1 □ Yes 2 mer (Specify) red	2 □No

To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dire Division of

27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29a. Certifier (Check only one) 29b. Signature and title of certifier

P. V. Norge M.

29c. License number HD 00065733 29d. Date signed (Month, Day, Year) 12/06/10

FILKTON, MD

STReet

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NARMANA (As V. PULA 126 A E

, 126 A EAST NARAMANA

31. Date filed (Month, Day, Year)

DEC 1 3 2010



Medical

State

Registrar

MGH

Registrar

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cheryl A. Aylesworth M.D.

26 2010

29c. License number

D59378

2730 University Blvd.W #400 Wheaton, Md

29d. Date signed (Month, Day, Year) Nov.24,2010

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Lest) 2. Date of Deeth 3. Time of Death Month **Physician** 05:30 AM 2010 -RED .J. SHIFFLEI /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner RIDGEWAY MANOR HURSING HOME BALTIMURE TONSVILLE A If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) 6. Sex 5. Social Security Number **Funeral** Devs Hours Months 11XM 2□ F 230-50-5495 Director Usuel Residence of Decedent Pages 1 end 2 should be filed within 72 hours efter deeth with the Marylend nant of Heelth end Mentel Hygiene. Int: If Item 27 is markad other than "natural", or thams 23a or 28a-f ahow 10d. Inside City Limits 10c. City, Town or Location 10a, Stete 10b County ? Is marked other than "natural", or thams 23s or 28s-f show traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 603 Meyers Drive 21228 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No 1958— If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify White ģ 3 ☐ Widowed 4 ☐ Divorced 1962 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Machinist MTA Transit_Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Fred C. Shifflett Mabel Lee Nalls 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 a Depertment of Heelth er Important: If Item 27 is any Injury or other trau Dorothy I. Shifflett - wife 603 Meyers Drive Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 14 Buria! 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park 11-30-10 Baltimore City 22. Name and Address of Fecility Harry H. Witzke's Family F.H.Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Pert1. Enter the disease, or complications that sised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final diseese or condition resulting in death) Examiner Completed by Physician/Medical Examiner the attending physicien end thed for use es the bunel-transit or Attanding Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as e consequence of) is certificate has been signed by the a director, page 2 should be datached i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 TNo 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy TLI Yes 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Aursing Home 5 ☐ Residence 6 ☐ Other (Specify) this : After this funeral 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 1 Watural 5 [] Pending 1 ☐ Yes 2 ☐ No deeth. investigation by the f 2 Accident efter deeth 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide within 24 hours e To the Funeral C complataly filled To the Hospital edical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Yeer) 29b. Signature and title of certifier 29 res 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Prijst) Rel on Leis asmor le no 2124 41 telhal mund P Koure 400 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State NOV 29 parks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 0 1 0 3 9 2 5 0										39250		
			Registrar 1. Decedent's Name (First, Middle, Last,)			timouto or E	Journ		2. Date of Deat	h		3. Time of Death	
	Physicia	_		E. SMITH		JR.				NOVEMB:	ER 22	Year	9:55 P M	
1	Medic		4a. Facility Name (if not institution, give s				4b. City, Town, or	Location o		NO V LLID	4c. Coun	ty of Death	1 7:33 1	
. ;	Examin	er	15115 INTERLACHE				SILVER S					TGOME	RY	
	Funeral		5. Social Security Number 6. Sec	7. Age	(In yrs. la	ast birthday)	If Under 1 Year	If Under 2	24 Hrs.	3. Date of Birth		9. Birth	place (State or Foreign	
87	Director		579-46-2661	M 2 □ F	76	Yrs.	Months Days	Hours	Min.	Month, Day, JULY 9	1934	WASH	INGTON, DC	
	3		Usual Residence of Decedent										10d. Inside City Limits	
	Maryland 28a-f show otified at	형	10a. State 10b. County		10c. City	, Town or Lo	cation						1 X Yes 2 □ No	
	Man 28a- otifie	Director	MD MONTGOME	RY	SI	LVER								
	h the	a	10e. Street and Number	THE DESIGNATION			10f. Zip Code				10g. Citizen o	T WHAT COU	ntry r	
	th with ms 2% must	Funeral	15115 INTERLACHI	12. Was Decedent E	in 11 C	140.1	2090		nin? /Speci	fy Vas or No-	USA	ace - Americ	an Indian	
	r iter iner	3	11. Marital Status 1 ☐ Never Married 2 X Married	Armed Forces?), [13. \	Was Decedent of H f Yes, specify Cuba	an, Mexican	, Puerto Ri	can, etc.)		ack, White,		
36	after al", o Exam	d by	3 Widowed 4 Divorced Year or Dates.			-	I ☐ Yes 2 🗓 No			Speci	fy: BL	ACK		
21215-0036	atura ical E	Completed	15. Decedent's Ed	ucation	16a. Decedent's Usual Occupation (Give kind of work done during most of work				16b. Kind of Busin			dustry		
75	n 72 l an "r Med	티	(Specify only highest grade Elementary/Seconday (0-12)	College (1-4 or 5	+)	(Give life. D	kind of work done (O NOT use retired)	dunng most	of working					
21;	withii giene er th , the		zionionary osseriata y (o 12)	4yrs		CIA	A SPECIAL	AGEN	T		GOVE	RNMEN'	r	
pu	filed al Hy d oth		17. Father's Name (First, Middle, Last)							First, Middle, N		me)		
<u>yla</u>	d be Ment arke	일	WILMER E. SMITH	SR.						CARRIN			20006	
Maryland	shoul and is m		19a. Informant's Name/Relationship (Ty)			19b. Mailir	ng Address (Street	and Numbe	er or Rural I	Route Number,	City or Town	State, Zip	Code) 20906	
	ind 2 lealth im 27 her tr		CAROLYN A. SMITH	WIFE	T ani . 5			CHEN			20c. Locatio			
Ore	ge 1 a t of h If ite or ot		20a. Method of Disposition 1 XBurial 2 Cremation 3	Removal from State	С	emetery, crer	nsition (Name of matory or other place		Da					
ţį	4 Donation 5 Other Specify FT. LINCOLN CEMI							11/26/2010 BRENTWOOD, MARYLAND Cility J.B.JENKINS FUNERAL HOME, INC.						
Bal	permit Depar Impor any in		21. Signature of Funeral Service License	ee /	-		2. Name and Addre 7ム7ム T.AND						AND 20785	
			23a Part 1 Enter the disease or comm	lications that caused	the deat								Approximate	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Approximate Interval Between Onset and Death											
-	Physician/ Medical		disease or condition resulting in death) 4. HEAD & NECK CANCER Due to (or as a consequence of):											
100	Examiner			Due to (or as a	consequ	derice orj.								
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury											
	ted d ansit	ical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.											
	be executed sician and burial-transit	Ä	resulting in death) Last	Due to (or as a	consequ	uence of):						1		
0	e be exe ysician ie burial	lica		d										
9289	ifficat ng ph as th	Mec	IF FEMALE:						_					
23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?									23d. Date of delivery Month Day Year					
Box	deat he at led fo	sic	1 Yes 2 No 9 Unknown	4 ☐ Pregnant a 9 ☐ Unknown	time of o	death 5 L	Other (specify)					Worth Day loa		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									bacco use co	cco use contribute to the cause of death?				
	es th signe	d b								1 🗆 Y	′es 2 □ No	3 🗆 Pro	obably 4 🛭 Unknown	
A Becord autopsy performed? 1 □ Yes 2 X Not 1 □ 24a. Was an autopsy performed? 1 □ Yes 2 X Not 1 □								an 24	b. Were auto	opsy findings available				
								death?	ompletion of cause of					
								th /Check						
íta	sicial certii irecto	o Be	examiner? Hospital: Other:							Home 5 X Residence 6 Other (Specify)				
<u>}</u>	Phy er this eral d	e: To	27. Manner of Death	28a. Date of inju	ry	28b. Time o	f 28c. Inju	ry at		8d. Describe h			, , , , , , , , , , , , , , , , , , , ,	
n C	nding ath. r: Afte e fun	icat	1 X Natural 5 ☐ Pending 2 ☐ AccidentInvestigation		, rear)	injury	M 1 🗆	Yes 2] No					
Sign	Atte er de ectol by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubuilding, etc	ry - At ho	ome, farm, st	reet, factory, office		2	8f. Location (S		nber or Run	al Route Number,	
ō.	tal or rs afte al Dir													
	Hospital 24 hours a Funeral I	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Exami	ner: On the basis of a	vaminatio	in and/or inves	stigation, in my opin	ion, death o	ccurred at t	the time, date a	nd place, and	due to the c	ause(s) and manner stated.	
	the thin 2 the the thin 2	Ĭ.	only one) 3 Certifying Nurs 29b. Signatura and title of certifier	e Practioner: To the	best of m	y knowledge,	death occurred at the		e and place		e cause(s) and 29d. Date sig			
	Vit To		1 Ster 11	11115	r	PNP		3201			11/	241	10	
	d		30. Name and address of person who d	completed cause of d	eath (Item	n 23a) (Type		10201				- 1/	10	
1	28		DEBRAH MILLER CR		1UNC	ASTER 1	MILL ROAI	ROCK	(VILLI	E,MARYL	AND 2	0850		
	Sta	te		32. Regist										
	Registr		NUV30 ZUIU 🔏	energy D.	19	action								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Certificate of Death

Registrar

39253

		1	For State of Walyland / Department of Health and Wental Hygiene State Registrar Amend #1 perfuneral home 11/30/204/06/66 to 1/30/204/06/66 66 to 1/30/204/06/66 to 1/30/204/06/60 60/06/60/60/06/60/06/60/06/60/60/
	Physicia	n/	
-	Medic	al	a. Facility Name (f not institution, give street and number) 2. Date of Death Month Day Year November 23, 250 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death
-	Examin		university of maryland medical Center Backimone, maryland BALTIMORE CITY
	Funeral		Social Security Number 6, Sex 7, Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9, Birthplace (State or Foreign
	Director		217-92-4817 1 M 2 X F 48 Yrs. Months Days Hours Min. MAY 1 T, 1962 MARYLAND
	and show lat	or	Oa. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Maryl 28a-f otifiec	rec	MARYLAND CHARLES HUGHESVILLE 1 X Yes 2 No
	th the	Funeral Director	0e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6452 VALYN DRIVE 20637 UNITED STATES
	ath wi	une	
36	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. It item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. If Yes, specify: No Specify: Specify: RI.ACK
9-9	hours natura lical E	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
215	nin 72 ne. han "ı e Med	omp	(Specify only highest grade completed) Elementary/Seconday (0-12) Online College (1-4 or 5+) College (1-4 or 5+) HOMEMAKER HOMEMAKER
121	d with tygien ther t	Be C	
<u>lanc</u>	be file ental F rked o ic eve	To E	7. Father's Name (First, Middle, Last) JOHN WILLIAM HARLEY 18. Mother's Name (First, Middle, Maiden Surname) THELMA CECELIA PROCTOR HARLEY
lary	should and M is mai		9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	and 2 s Health em 27 ther tr		TONYA A.SWANN / DAUGHTER 3333 WESTDALE COURT, WALDORF, MARYLAND 20601
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t		0a. Method of Disposition 1
Balt			THORNTON JOHNSON MOO583 21 Normand Address Figure 1 Figure 2 Funds 1 Figure 2 Figur
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
	Physician/		Immediate Cause (Final disease or condition
-	Medical Examiner		resulting in death) Due to (or as a consequence of):
		ner	Sequentially list conditions, f any, leading to immediate cause. Enter Underlying
	tuted nd ransit	Examiner	Cause (Disease or linjury
	e exec cian ar vurial-t		resulting in death) Last Due to (or as a consequence of):
3760	cate b physic	edic	d
98	certific nding use as	ın/M	FEMALE: 3b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery
Division of Vital Records, P.O. Box 68	death he atte ed for	Physician/Medical	In the past 12 months? 1
ξ <u>ο</u> :	at the d by ti	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
S.	ires th signe Id be o	d by	1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 🕽 Unknown
#2	w requ	Completed	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
Jec.	The lay ate has)om	autopsy prior to completion of cause of performed? death? 1 ★ Yes 2 □ No 1 □ Yes 2 □ No
ta_	cian: - ertifica ector, I	Be	5. Was case referred to medical exampler? Hospital: 26. Place of Death (Check only one)
Ę.	Physic this cral dire	٦.	Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 7. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
o u	ath. : After e fune	icate	1 Natural 5 Pending (Month, Day, Year) injury work? 2 Accident investigation M 1 Yes 2 No
/isic	r Atter ter deg rector	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
ă	urs aff urs aff ral Di		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check (Check only one) as Stated. 29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the within To the comp	2	9b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
			November 23, 2010
	NB2		0. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOVIE Grant 22 S. Greene St. Bautmae, MD 01201
	Stat	te	1. Date filed (Month, Day, Year) 32. Registrar's Signature
	Registra		NOV 34 2010 June B. Sales

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2ďľ0 01:00 AM November <u>Kenneth Martin Tate</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cecil North East 47 Mansion Drive If Under 1 Year If Under 24 Hrs. Funeral Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1**XX**M 2 □ F Hours 0*671171*4941 Pennsylvania Director 69 156-32-8508 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Ceci1 North East Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 47 Mansion Drive 21901 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2XXNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Produce Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Maxine Reinburger Kenneth Anton Tate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21901 47 Mansion Drive, North East, Maryland Linda Tate / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2x Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Ngvember Mayerdale Crematory Newark, Delaware 22. Name and Address of Facility Crouch Funeral Home 21. Signature of Fundal Pervice Lie 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ Camethe Medical resulting in death) Examiner Conton Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Prostelle Co 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of death? certificate cardiac 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ္ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this I in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined 24 hours a Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) Don' ceril Nan (1)

Registrar

State

31. Date filed (M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 22 Day Richard Beck Underwood 2010 4:32 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Annapolis Anne Arundel Medical Center Anne Arundel If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Massachusetts 5. Social Security Number 7. Age (In yrs. last birthday) 71 vrs 8. Date of Birth **Funeral** Days 1 🕱 M 2 🗆 F Director 029-28-8324 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must ha maifind a 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Prince George's Bowie 1 X Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 811 Falls Lake Drive 20721 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 🙀 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Train Operator **METRO** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Beck Underwood, Sr. Viola Reid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 811 Falls Lake Dr., Bowie, MD 20721 Julie Underwood/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematorÿ11/30/2010 Alexandria, VA 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service Licenses 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequen of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician a s the burial-Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available cate has bage 2 s autopsy performe prior to completion of cause of death? 2.2 110 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: ျှ 1, Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1- Natural injury 5 Pending n 24 hours after connections A felled in by the f 2 Accident
3 Suicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ense number S (1

State Registrar Name and address

Date filed (Month)

s of persor

o completed cause of death (Item 23a) (Type, Print)

Vivian Eileen Van Voorhis 4a. Facility Name (if not institution, give street and number) 14a Southern Oak Drive Funeral Director Funeral Director Funeral Director August 1 of 1 o	ryland 10d. Inside City Limits 1 Yes 2 X No
Vivian Eileen Van Voorhis 4a. Facility Name (if not institution, give street and number) 148 Southern Oak Drive 4b. City, Town, or Location of Death Hagerstown 4c. County of Death Washington Funeral Director 5. Social Security Number 216-22-8206 1 M 2XF 84 Yrs. 6. Sex Months Days Hours Min. Wov. 17, 1926 Max Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	place (State or Foreign ntry) ryland 10d. Inside City Limits 1 Yes 2 No
The state of Decedent Topic County Southern Oak Drive Hagerstown Hagerstown Hagerstown Hagerstown Hagerstown Funder 1 Year of Under 24Hrs. Southern Oak Dryyyy 9. Births, County Months Days Hours Min. Nov. 17, 1926 Max. Usual Residence of Decedent 10b. County 10c. City, Town or Location 11c.	ryland 10d. Inside City Limits 1 Yes 2 X No
Director 216-22-8206 1 M 2 F 84 Yrs. Months Days Hours Min. Nov. 17, 1926 Man Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	ryland 10d. Inside City Limits 1 Yes 2 X No
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c. City, Town or Location	ryland 10d. Inside City Limits 1 Yes 2 X No
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 1	1 Yes 2 No
Maryland Washington Hagerstown 10e. Street and Number 10e. Street and Number 10f. Zip Code 11g. Was Decedent of Hispanic Origin? (Specify Yes or Nofit Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent of Hispanic Origin? (Specify Yes or Nofit Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12g. Street and Number 11g. Was Decedent Ever in U.S. 11g. Was Decedent of Hispanic Origin? (Specify Yes or Nofit Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12g. Street and Number 11g. Street and Number 11g. Was Decedent of Hispanic Origin? (Specify Yes or Nofit Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11g. Was Decedent of Hispanic Origin? (Specify Yes or Nofit Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 12g. Was Decedent of Hispanic Origin? (Specify Yes or Nofit Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 12g. Was Decedent of Hispanic Origin? (Specify Yes or Nofit Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 12g. Was Decedent of Hispanic Origin? (Specify Yes or Nofit Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 12g. Was Decedent of Hispanic Origin? (Specify Yes or Nofit Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 12g. Was Decedent of Hispanic Origin? (Specify Yes or Nofit Yes, Specify Cuban, Mexican, Puerto Rican, etc.)	1 Yes 2 No
Harried Forces? The state of t	
148 Southern Oak Drive 148 Southern Oak Drive 15	
The state of the s	
Never Married 2 Married 1 Yes 2 X No 1 Yes 2 X No specify: Specify: Wh:	an Indian, Black,
Specify: WIT:	
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Ind	
9 10 10 10 10 10 10 10 10 10 10 10 10 10	
Owner/Operator Automobi	ile
기 (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) 18.Mother's	
To go	
Cheryl A. Kline / Daughter 719 Naples Drive Hagerstown, Maryland	21740
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or To crematory or other place)	own, State
Mt. Lena Cemetery 12/03/2010 Mt. Lena, I	Maryland
21. Signar re of Thera Strice Licensee 22. Name and Address of Facility Bast-Stauffer Funeral 7606 Old National Pike Boonsboro, MD	
Physician 23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	Approximate Interval
failure. List only one cause on each life. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease	Between Onset and Death
or condition resulting in death) Due to (or as a consequence of): b. complicated by Inferior Vena Cava Thrombosis	
3 Section Relative to a Carton is,	
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):	
pannon d	
e be e, e be e	
So to the state of	y Year
So y	, Teal
O B 9	a source of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the large figure and t	
24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes	psy findings available
autopsy prior to com death? Vest 2 No 1 Vest 2 Vest 2 No 1 Vest 2 Vest 2 No 1 Vest 2	npletion of cause of
P c s s de l s s de	2 No
25. Place of Death (Check only one) 26. Place of Death (Check only one) 26. Place of Death (Check only one) 27. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Death (Check only one)	icene
24a. Was an autopsy performed? The part of the part o	
Vigoria Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural 28e. Place of Injury - At home, farm, street, factory, etc. 28f. Location (Street and Number or Rural 28e.	Route Number City
To so the standard of the stan	reduce realison, only
6 - 4 5 1 298, Cettilet 1 1 2	
To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and date and place, and due to the cause(s) and date and place, and	
29c. Signature and title or certifier 29d. Date signed (Month,	
November 29, 2010 30. Name and address of person who completed cause of death (Item 23a)	
Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day, Year) Registrar NOV 3 2010	

DHMH 17 Rev 1/2001 OCME 2006

OCME

		Pleas	e Type or Print in				-	_	•
		For State	State of Maryla	=			Mental Hy	giene	39257
		Registrar 1. Decedent's Name (First, Middle, L.	act)	Cer	TITICALE	of Death	2. Date of De	Reg. No.	
Physic Med	ian/ dical	Mortor	s 6 Von	Duyk	e		Month 11	Day Year	3. Time of Death
Exam	iner	4a. Facility Name (if not institution, git		J	_	Town, or Location of Death	1	4c. County of Dea	th .
Funera Directo		5. Social Security Number 6.	Sex 1 M 2 □ F 7. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Bir (Month, Da	th ly, Year) 0, 1918	thplace (State or Foreign ountry)
T. Mg		Usual Residence of Decedent	l to o				, , , , , , , , , , , , , , , , , , , 		
Baltimore, Maryland 21215-0036 Popertnent of Health and Mental Hygiene To hours after death with the Maryland Department of Health and Mental Hygiene Inportant; fitten 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	Director	VA FAIR		SPRIN	GFIE				10d. Inside City Limits 1 ☐ Yes 2 🔀 No
with the s 23a or	Funeral D	10e. Street and Number 5611 HENIN	16 AVENUE		10f. Zip	Code 22151		10g. Citizen of What C	ountry?
death item	Ţ	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. V		ent of Hispanic Origin? (Sp ify Cuban, Mexican, Puert		14. Race - Ame Black, Whit	
Baltimore, Maryland 21215-0036 semit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exami	ed by	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates. ↓ 1 - ↓	6	I ☐ Yes 2	No Specify:		Specify: W	
5-0 2 hour "natu	plete	15. Decedent's (Specify only highest of	Education	16a. Deced		l Occupation	kina	16b. Kind of Business	Industry
121 Ithin 73 ene. than	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)		ONOT use I	retired)	·····g	RFE-R	L INC.
iled willed will will will will will will will wil	a a	17. Father's Name (First, Middle, Last)	1 3			ne (First, Middle,	Maiden Surname)	
/lan d be fi Menta arked	₽	HARRISON 1	norton von	Duyke	2	RUTI	+ Br	ELDEN	
Many shoul shoul I sis mis raums		19a. Informant's Name/Relationship				(Street and Number or Ru			p Code)
more, Magge 1 and 2 st age 1 and 2 st ant of Health a nt. If item 27 is		20a. Method of Disposition	UON DUYKE/WIFE	Place of Dispo			SPRING	20c. Location - City of	ZZISI
mor mor age 1 ent of mr. If if		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	Removal from State	cemetery, cren	natory or otl	her place)	11/2010	Falls Clt	
altii	dice.	21. Signature of Funeral Service Lice				Address of Facility		5308 Bac	klick Rd-
— a a a a a a	5	Suren glisc	5 C C C C C C C C C C C C C C C C C C C			inefunera		Springfield,	VA 22151
2 Physician		23a. Part 1. Enter the discase, or co shock, or heart failure. List only Immediate Cause (Final disease or condition	mplications that caused the dea one cause on each line.	ath. Do not ente	er the mode	of dying, such as cardiac	or respiratory ar	rest, (Approximate Interval Between Onset and Death
Medica Examine	er	resulting in death)	Due to (or as a consec	quence of):					
The state of the s	Examiner	Sequentially list conditions, it day, leading to instructions cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consec	quetioe ut;.				<u></u>	
be executed sician and burial-track	cal Ex	that initiated events resulting in death) Last	Due to (or as a consec	quence of):					
760 ate be	gdici	•	d						
ision of Vital Records, P.O. Box 68760 Attending Physician: The law requires that the death certificate be executed ar death. ector: After this certificate has been signed by the attending physician and extremely from the page 2 should be detached for use as the burial-the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3 🗌	Ectopic pr Other (spe			23d. Date of de Month	ilivery Day Year
DUYK, ords, P.O. Borrequires that the deben signed by the should be detached		Part II. Other significant conditions	,	sulting in the u	inderlying ca	ause given in Part I.	23e. Did t	obacco use contribute to	the cause of death?
ds, ds, dulres sen sig	ted	Denne	n hal				1 🗆	Yes 2 No 3 □ F	robably 4 🗆 Unknown
Record The law require has been age 2 shou	Completed by	D W.					24a. Was auto perfo 1 \sum Yes	psy prior to death?	utopsy findings available completion of cause of
Wital Pysician: J	Be	25. Was case referred to medical examiner?				26. Place of Death (Che			
f Vi f Vi Physic this c	<u>ا</u>	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2	ER/Outpatier 28b. Time of		Other: 4 Nursing H		dence 6 Other (Spec	in Hospice
on on ording the.	cate	1 Natural 5 Pending 2 Accident Investigati	(Month, Day, Year)	injury	M	work? 1 🗆 Yes 2 🗆 No	28d. Describe r	now injury occurred	
	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 280 Place of Injury - At h		eet, factory,	office	28f. Location (\$ City or Tov	Street and Number or Ru vn, State)	ral Route Number,
biv biv the Hospital or hin 24 hours afti the Funeral Dir mpleted filled in	Medical	(Check 2 Medical Example (Check 2 Medical Exam	nysician: To the best of my know miner: On the basis of examinations of the best of n	on and/or invest	tigation, in m	ny opinion, death occurred	at the time, date a	and place, and due to the	cause(s) and manner stated.
To the complete compl	-	29b. Signature and title of certifier			29c.	License number		29d. Date signed (Mont	h, Day, Year)
020		P	Linko			H006426	7	11-a0-	10
-		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, P		en AV Balt	Mn 21	201	
S Regis	tate trar	31. Date filed (Month, Day, Year) NOV 2 9 20	32. Registrar's Sign	are So	R.P.	11 11 DULL	1:0- 5 18	<i>N V V</i>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 2010 8:10 a M Emma Hipsley Visnic Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Health & Rehab Center Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 □ M 2 🗓 F Months Davs Hours (Month, Day, Yea Mau 85 Director 214-20-6668 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location within 72 hours after death with the Maryland ral", or items 23a or 28a-f shore Examiner must be notified at Director Bethesda 1 Tes 2 No Maryland Montgomery 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Funeral 20814 U.S.A. 5721 Grosvenor Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", White 3 X Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 }
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event". Elementary/Seconday (0-12) College (1-4 or 5+) Bell Atlantic Administrative Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard J. Hipsley Beulah Ethel King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #12-M. New York. NY 10022 225 East 57th St.. Robert C. Baublitz - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State Lincoln Crematory 11/30/2010 | Brentwood, Maryland t. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licen 11800 New Hampshire Ave., Silver Spring, MD 20904 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. Li-Approximate Interval Between Onset an eath Immediate Cause (Final Physician/ neumoma disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events e attending physician and ad for use as the burial-thansit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the Unrerlal invector, page 2 should be detached for use as the burlat-lapagit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death
Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Osteoarthr: Lis 24a. Was an autopsy performed 1 Yes 2 No 1 ☐ Yes 2 🛣 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 X No Other: 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier winds 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dino Drin, Burtonsville, MD 20866. 115216 NURUL CHOW 31. Date filed (Month, Day, Year) NOV 29

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death November 22, Physician/ 3:00 A 2010 Irene Marie Walker Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mt. Airy Carroll Lorien 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Year 921 Hours oct 25, 1 □ M 2 🕱 F Minnesota Director 89 475-12-4441 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event the Marxin-1-10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No Maryland Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? Funeral 21043 United States 8358 Chestnut Farm Lane 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 XWidowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare <u>Registered Nurse</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ann Bramel Michael S. Karpowich Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8358 Chestnut Farm Lane Ellicott City, Maryland Michael Kent Walker/son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 11/26/2010 Woodbine, Maryland Sign Pe of Funeral Service Licen Going Home Cremation Service P.O. Box 784 uanta RARomas M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part Denter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hypertensive Cardiovascular Disease vears disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner quantistly list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No Day Month Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed? Yes 24 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 XNo 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 XNursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at nours after death.

neral Director: After the filled in by the funeral Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No injury 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) certifie 29c. License number 29b. Signature and 29d. Date signed (Month. Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

MECHA

Miller,

Ronald E.

31. Date filed (Month

D26499

4 Culwell Drive Mt. Airy, Maryland 21771

November 24, 2010

		1	State		rtment of Healt tificate of Deat		ıl Hygien Reg. I	4010	39260
			1. Decedent's Name (First, Middle, Last)	007	inouto or Boat		(0 "		3. Time of Death
	Physicia		Geraldine Frost Winpigler			De Moi	cember	Day Year 5, 2010	1:15 P ^M
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Locati	ion of Death		4c. County of Deat	
			Citizen's Rehab. & Nursing Ce	nter	Frederick			Frederic	
	Funeral Director		220-18-0165 1□M 2XF 8	yrs. last birthday) 86 Yrs.	If Under 1 Year If Un Months Days Hou	rs Min. 8. Date	e of Birth nth, Day Year per 10,	1924 9. Bird	hplace (State or Foreign Maryland
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County 10c	c. City, Town or Loc	ation				10d. Inside City Limits
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	Maryland Frederick	Frederio	·k				1 X Yes 2 □ No
	the N	₫	10e. Street and Number	1104011	10f. Zip Code		1	Citizen of What Co	-
	s 23a	era	355 Montevue Lane		21702			United S	tates
	death item ner m		11. Marital Status 12. Was Decedent Ever in Armed Forces?		Vas Decedent of Hispanic Yes, specify Cuban, Mex			14. Race - Ame Black, White	
36	after II", or xamii	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	1	☐ Yes 2 🗷 No Spe	cify:		Specify: Wh	ite
21215-0036	atura cal E	Completed	15. Decedent's Education	16a. Deced	ent's Usual Occupation		16b	. Kind of Business	
215	an "n Medi	ם	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)		ind of work done during r O NOT use retired)	most of working			
212	withir giene er tha		7		Nursing Aide	<u> </u>		Medica	1
Maryland	filed tal Hy d oth event		17. Father's Name (First, Middle, Last)		I **	Nother's Name (First,		*	
yla	ald be Meni narke	욘	Clayton Calvin Lenhart			Effie Elle			
Mar	shot h and 7 is n traum		19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Nu Edgewood Cl				
e)	and 2 Healt tem 2	30	Clarence Winpigler / Son 20a. Method of Disposition	Oh. Place of Dispo	sition (Name of			. Location - City or	
Baltimore,	age 1 ent of nt: If ii		1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		natory or other place) g Crematory	December	,	ai thabusa	, Maryland
alti.	mit. P partme portar injur		21. Signature of Funeral Service Ligensee		. Name and Address of Fa eeney and Ba				, Mary Tanu
ä	permit Depar Impor any in		MO MO	1473	geney and ba 06 East Chui	rch St., I	rederi	ick, Mary	land 21701
			23a. Pa 1. Enter the diseas or complications that caused the shock, or heart failure. Let only one cause on each line.	death. Do not ente	r the mode of dying, such	h as cardiac or respir	atory arrest,		Approximate Interval Between
Jan.	Physician/		Immediate Cause (Final disease or condition	ESTIVE	HEAR	T FF	ILUR	E	Onset and Death クタンら
삪	Medical Examiner		resulting in death) Due to (or as a con						
		Jer	Sequentially list conditions, b. Due to lor as a col	nso juence of:					
	ted insit	Examiner	if a y leading to in misdlating cause. Enter Underlying Cause (Disease or iinjury						
	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	EX	that initiated events c. Due to (or as a co	nsequence of):					
09	le be nysicia ne bur	edical	d						
	tificating ph	Μe.	IF FEMALE:						
Box 687	ath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of p 1 ☐ Live Birth 2 4 ☐ Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	e dea the a thed f	Physician/M	1 Yes 2 No 4 Pregnant at tim 9 Unknown 9 Unknown	le of death 3 L	Other (specify)				
P.0.	requires that the de been signed by the should be detached	y Ph	Part II. Other significant conditions contributing to death but n	ot resulting in the u	nderlying cause given in l	Part I. 23	e. Did tobacc	co use contribute to	the cause of death?
	n sign	ed by					1 🗆 Yes	2 🗆 No 3 🗆 P	robably 4 Tunknown
ord	v requ	Completed				24	la. Was an autopsy		topsy findings available completion of cause of
Sec.	sician: The law I certificate has t lirector, page 2 s	E O		·		1	performed Yes 2	? death?	s 2 🗆 No
alF	ian: T rtifica ctor, p	Be C	25. Was case referred to medical examiner?		26. Place of	Death (Check only o			
ξ	Physic this ce	ြို	1 Yes 2 No Hospital.	2 ER/Outpatier		Nursing Home 5			eify)
1 0	ing P	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Ye	ear) 28b. Time of injury	work?		escribe how in	njury occurred	
ior	Attending ar death. ector: After by the fune	tific	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury -	At home, farm, str			cation (Street	and Number or Ru	ral Route Number.
Division of Vital Records,	lor A after Direc	Cer	4 Homicide determined building, etc. (S)		3 ,		y or Town, St		
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical Certificate:	29a. Certifier 1 Certifying Physician: To the best of my (Check 2 Medical Examiner: On the basis of exam	knowledge, death	occured at the time, date	and place, and due t	o the cause(s) and manner as st	ated.
	the Hu lin 24 the Fu	Mec	Year Control of the Name of Department of the board	A -4 Leaguilodas	don'th accoursed at the time.	date and place and	tue to the cau	ea(e) and manner as	etated
_	Vith Vith Con		29b. Signature and title of confiner		29c. License numl	ber	29d.	Date signed (Mont	h, Day, Year)
			INC MI)		1006	1410		nec, c	6, 20/0
			30. Name and address of person who completed cause of death GAFFAR SYED &	(Item 23a) (Type, F	29c. License numl Doo 6 /	OVE I	ERED	DERICK	, MD
	Sta	te.	31. Date filed (Month, Day, Year) 32. R gistrar's	Signature	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				<u> </u>
	Registr		DEC 13 2010 General A. A	War					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ NOV. 2010 Year Annette Lorraine Weber 11:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard 9125 Dunloggin Road Ellicott City 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8 Date of Birth Birthplace (State or Foreign Country) 1 🗆 M 2 🛚 Days 1272771930 79 457 42 0303 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No NC Wake Raleigh 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 5101 Tanglewild Drive 27613 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 Married Completed by 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emil Faltisek Helen Keprta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maurice S. Weber/Husband 5101 Tanglewild Drive Raleigh, NC 27613 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cometery, crematory or other place)

Raleigh Memorial Park 11-30-2010 Raleigh, NC 1 Burial 2 Cremation 3 K Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final carcinamatosis disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, Examine Dué to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🔀 No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 XNo 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Daughter's examiner? 1 ☐ Yes 2 🄀 No Hospital Other: မှ 4 Nursing Home 5 Residence 6 Nother (Specify)

Medical Examiner and -transit or Attending Physician: The law requires that the death certificate be executed physician a Records, P.O. Box 68760 attending p been signed by the s page 2 s this certificate has Division of Vital funeral director, nours after death.
neral Director; After the filled in by the funera

27. Manner of Death

1X Natural

3 Suicide 4 Homicide

only one) 29b. Signature and title of certifier

29a. Certifier

Accident

5 Pending

Investigation

determined

6 Could not be

Enda W

Brenda M. Weber, M. C

Certificate:

Medical

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

72 hours after death

Maryland 21215-0036

Baltimore.

and Mental Hygiene. is marked other than "natural", or i

1 and 2 s of Health a item 27 i

ō Department of Important: If it

traumatic event, the Medical

injury or

'n

Physician/

State

24 hours a Hospital

To the h

within 24 hor To the Fune completed fil

Registrar

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

injury

28c. Injury at work?

2 Gertifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

9125 Dunloggin Rd., Ellicott City, MD 21047

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28a. Date of injury (Month, Day, Year)

User M.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death Month Physician/ ERMA М WHITMORE NOVEMBER 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 90 yrs. 9. Birthplace (State or Foreign 6. Sex 8 Date of Birth **Funeral** 1 🗆 M 2 🔀 F Days Hours 213-18-9447 Maryland Director Usual Residence of Deceden 10a. State Berkeley permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at . City, Town or Location Bunker Hill 10d. Inside City Limits Director 1X Yes 2 No 10f. Zip Code 25413 10e. Street and Number 10g. Citizen of What Country? United States Funeral 21 Impressive Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname)
May E. Ferguson 17. Father's Name (First, Middle, Last) Rhomer C. Minnick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 Impressive Drive, Bunker Hill, WV 25413 Glenn W. Whitmore-Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 X Removal from State Edge HiTT Cemetery Dec. 1,2010 Charles Town, WV 4 ☐ Donation 5 ☐ Other (Specify) Melvin T. Strider Co.Inc. PO Box 388, Charles Town, WV 21. Signature of Funeral Service Licensee 23a. Part 1 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Yes 2 No 9 Unknown cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 Yes 2 No Yes 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director; After injury work?
1 Yes 2 No 1 Natural 5 Pendina Accident Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JH-5 Thomas 5h 65 0

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Resistrar's Signature

			For State Registrar	State of Mary		artment of Hertificate of E		1ental Hygie Reg.	7 0 1	0 (39263
· A	£		Decedent's Name (First, Middle, Last)					2. Date of Death	Day	Year	3. Time of Death
	Physicia		Bernhard		Wit	kop		November			7:10A M
	/Medic	V	4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, or	Location of Death		4c. County o		
	Examin	er	3807 Montrose Drive			North Che	evv Chase]	Montgo	mery	
	Funeral		5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	arl	9. Birthpla	ace (State or Foreign
	Director		578-46-3122	^{2□F} 93	Yrs.	Months Days	Hours Min.	May 9,191		Germa	
	o o		Usual Residence of Decedent							10	d. Inside City Limits
	nylan how		10a. State 10b. County	10	c. City, Town or Lo	cation				10	14 Yes 2 No
	a-f-e	cto	Maryland Montgomery	l l	North Che	vy Chase					
	th the	Directo	10e. Street and Number			10f. Zip Code		10g.	Citizen of W	hat Count	try?
	th wi	18	3807 Montrose Driv	eway		20815			JSA		
	n dea	Funeral	11. Marital Status	!. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- America , White, e	
õ	or It	F	1 Never Married 2 Married	1 ☐ Yes 2 📆 No If Yes, Give 🛣		1 ☐ Yes 2 🎇 No	Specify:		Specify:	Wha	ite
215-0036	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. dethygiene. dether than "natural", or items 23e or 28e-f show event, the Madical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	160 Daga	dent's Usual Occupa	tion	161	o. Kind of Bus		
Ÿ	"nat	Completed	15. Decedent's Educa (Specify only highest grade		(Give	kind of work done d DO NOT use retired.	furing most of work	king	J. 1411G OF DO.		
7	withir	m d	Elementary/Secondary (0-12)	College (1-4or 5+)	Scien	,		N	IH		
N.	Hygie ther ther	e Co	17. Father's Name (First, Middle, Last)		5020.		18. Mother's Nam	e (First, Middle, Mai		a)	
Maryland	ntal ed o	o Be	Philipp W. Witke	מכ			Hedwig	Hirs	chorn		
2	should and Men marke umaric	ĭ	19a. Informant's Name/Relationship (Type		19b. Maili	ng Address (Street a		ral Route Number, C	ity or Town, S	State, Zip	Code)
Z Z	d 2 s th an th an trau		Thomas G. Witkop/So					evy Chase,			
	ies 1 and 2 should be filed vol Health and Mental Hygies If Itam 27 is marked other for other traumatic event, the	1	20a. Method of Disposition		20b. Place of Dispo				c. Location - (wn, State
altimore,	Pages nent of int: If It iny or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Kalas Cr	•		7/2010 Ed	loewate	or M	Maryland
	artme ortan injur	1	21. Signature & Funeral Service Licenges	1			and the second s	rge P, Kai			
B B	permit. Pages Department of I Important: If Its any injury or o	e 1	Voet Calar	·/h				Oxon Hill			
			23a. Part1. Enter the disease, or complication	ations that caused the						20173	Approximate Interval Between
	<i>E</i> ;		shock, or heart failure. List only one Immediate Cause (Final	dause on each line.		1	1	1			Onset and Death
(6) (5)	Physician /Medical		disease or condition resulting in death)	Due to (or as a c		ardiovas	cular a	isease			years.
	Examiner			200 10 (01 43 4 0	01100 qu01100 017.						,
l.		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	onsequence of):						
	uted d ansit	ᇤ	cause. Enter Underlying Cause (Disease or injury that initiated events								
Ć.	be executed sician and burial-transit	Examiner	resulting in death) Last	Due to (or as a c	onsequence of):						
760	ite be executed lysician and he burial-transit	cal	d.								
9											
ŏ	death certifical e attending phi ed for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of p		□Ectopic pregnancy				e of delive	
Ď	death e atte	Cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at tim		Other (specify)			Mor	ntn	Day Year
Ö	tifle by th	hys	9 🗆 Unknown	9⊡ Unknown					1		
s, D	The law requires that the de ate has been signed by the a page 2 should be detached	by P	Part II. Other significant conditions cont	ributing to death but r	not resulting in the u	Inderlying cause give	en in Part I.		1		ne cause of death?
Ö	quire on sig		Hypertension,	conges	tive he	art tal	lure,	1 🗆 Yes	2 K No	3 Prob	ably 4 Unknown
Record		Completed	nalmonary hu	pertensi	on, nei	nal_insul	Hicience	24a. Was an autopsy	24b. V	Vere auto	psy findings available mpletion of cause of
	The lay te has	Eo	70000		,,,		/	performe	id3· c	leath?	2000
Vita	an: rtifica	BeC	25. Was case referred to medical				26. Place of Dea	ath (Check only one)			
>	ysici is ce direc	ToE	examiner? 1 ☐ Yes 2 No	ospital: 1 🔲 Inpatient	2 ER/Outpatie	int 3 DOA Oth	er: 4 🗌 Nursing H	lome 5 Residen	ce 6 □Oth	er (Specif	y)
0	ding Physician: The lar h. After this certificate has funeral director, page 2		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time (of 28c. Injury Wor	y at k?	28d. Describe how	injury occurr	ed	
ō	ath. or: Af	atle	2 Accident investigation			M 1 🗆	Yes 2 □ No				
Division of	or Attendated after death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (At home, farm, s Specify) 	reet, factory, office		28f. Location (Stre City or Town,		er or Rura	al Route Number,
	talo rs aft al Di	Cer									
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edical	(Check only 2 Medical Examin	ician: To the best of a er: On the basis of ex	camination and/or i	th occurred at the tir nvestigation, in my o	ne, date and place pinion, death occu	e, and due to the cau urred at the time, dat	se(s) and ma e and place,	inner as s and due to	stated. the cause(s)
	the the the function 2	Med	one)	and manner state		29c. Licens	e number	290	d. Date signe	d Month.	Dav. Year)
	To To	2	29b. Signature and title of certifier	ba Ma	4, 900	175	1916	N	buemi	hen	22,2010
•			latricia /ome	-0	7, 100	100	. 110	1/0	U - my	/ -	
	1		30. Name and address of person who cor		th (Item 23a) (Type	Print) 1/2 b	1/2 N-11	on Parts.	11/0 1	MA	10850
			31. Date filed (Month, Day, Year)	32 Registrar's	Signatura -	VIIIE P	INE, 6-16	NOUNVI	116, 1	10.	20, 2010 20852
() F.	St Regist	ate rar	NOV3 0 2010	me d.	Signature						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Watkins Mary Α. 12:16PM 2010 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Capitol Heights Constant Care 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) **Funeral** 1 M 2 XF Hours Director 238-28-9398 90 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Hyattsville MD Prince George's 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 20785 USA 6711 Asset Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 0. Completed by 1 Never Married 2 Married Yes Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Tes 2 No Specify Specify: Black "natural", 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Turner Hosea Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6711 Asset Drive Hyattsville, MD Darlese Green / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗌 Cremation 3 🗆 Removal from State Fort Lincoln Cemetery 11/26/10 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD Signature of Funeral Sa icensee 22. Name and Address of Facility Fort Lincoln Funeral Home rances 3401 Bladensburg Rd Brentwood, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Pnysician disease or condition Congestive Heart Failure Medical resulting in death) Due to (or as a consequence of): Examiner Cardiovascular Insufficiency Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signipage 2 should be 1 Tes 2 No 3 Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 ☐ Yes 2 🛣 No 1 Yes 2 🗆 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisted Living Other: 4 \square Nursing Home 5 \square Residence 6 \boxtimes Other (Specify) မ 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 🔀 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be 2 Accident completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time date and place, and due to the cause(s) and manner stated. 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nous D23743 November 24, 2010

Registrar

State

7525 Greenway Ctr Dr

32. Registrar's Signature

Greenbelt, Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Martin D. Weltz,

31. Date filed (Month, Day, Year NOV 3 0 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			State of	Maryland / Depa	artment of H	lealth ar	nd Mental Hy	giene	
			State Registrar	Cer	tificate of <i>E</i>	Death		Reg. No?	39265
	Discrisis	.,	Decedent's Name (First, Middle, Last)				2. Date of De	ath	3. Time of Death
	Physicia Medio		Vivian G. Waddill				NOVEM!	BER 26 ZOI	8:01 PM
	Examin	er	4a. Facility Name (if not institution, give street and numbe		4b. City, Town, or	Location of D	Death	4c. County of Dea	
-~~	, 		Doctor's Community Hospit 5. Social Security Number 6. Sex 7.		Lanham If Under 1 Year	I If I Indox 04	The Lead of	Prince Ge	
	Funeral Director		1 M 2 STF	Age (In yrs. last birthday) Yrs.	Months Days	If Under 24 Hours	Hrs. 8. Date of Bird Min. (Month, Da 08/25/1		rthplace (State or Foreign puntry) hington, DC
		6	579-32-6194 Usual Residence of Decedent	0.0			100/23/1	.923	iiiiigtoii, DC
	shov dat	tor	10a. State 10b. County	10c. City, Town or Loc					10d. Inside City Limits
	Mary 28a-f otifie	Director	MD Prince George's	Glenn Dale	2				1 ¥ Yes 2 ☐ No
	a or	al D	10e. Street and Number		10f. Zip Code			10g, Citizen of What C	ountry?
	h with	Funeral	10116 Martin Avenue		20769			USA	
	r deat		11. Marital Status 12. Was Deceder Armed Force 1 Never Married 2 Married 1 Yes 2	s?	Vas Decedent of Hi Yes, specify Cuba	spanic Origin n, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Am Black, Whi	
38	al", o	d b	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates	1	☐ Yes 2 🛣 No	Specify:		Specify: B1	ack
ŏ	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at	Completed by	15. Decedent's Education		ent's Usual Occupa	ation		16b. Kind of Business	Industry
212	n 72 an "r	m d	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 of the control o	life DC	kind of work done d O NOT use retired)	uring most of	working		
2	withi giene rer th		11th		ry Techn	ician		Federal Go	vernment
n	should be filed wii and Mental Hygie is marked other aumatic event, th	o Be	17. Father's Name (First, Middle, Last)				Name (First, Middle,		
<u>y</u> a	should be file and Mental F is marked o raumatic eve	မ	Robert Goffney]]	Maggie	Alexander	•	
Jai	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print)	- 1				r, City or Town, State, Z	ip Code)
a)	and 2 steem 27 steem 27 steem 27 steem 27		Catherine Smith/Daughter 20a. Method of Disposition			ve., G	lenn Dale,		
Baltimore, Maryland 21215-0036	Page 1 ment of ant: If it ury or o		1 Burial 2 ☐ Cremation 3 ☐ Removal from Sta	20b. Place of Dispos cemetery, crem	natory or other place		Date	20c. Location - City o	
탪	permit. Pag Department Important: any injury c		4 Donation 5 Other (Specify)	Ft. Lincol				Brentwood, Iarch Funer	
Ba	permit. Departn Imports any inju	- 1	21. Signature of Funeral Service Licensee					id, MD 2074	
e. Č			23a. Part 1. Enter the disease, or complications that cause	sed the death. Do not ente					Approximate
3:	Physician/		shock, or heart failure. List only one cause on each Immediate Cause (Final						Interval Between Onset and Death
	Medical		disease or condition resulting in death) a. Due to (or a	Is a consequence of):	1 8W	1001	Mai		
	Examiner				0				
		iner	Sequentially list conditions, if any leading to imposite the cause. Enter Underlying	s a consequence of					
	outed nd ransit	Examiner	Cause (Disease or iinjury that initiated events c.						
	e exectian ar	E	resulting in death) Last Due to (or a	as a consequence of):					
2	certificate be executed nding physician and use as the burial-transit	dical	d						
/89	artifica ding p		IF FEMALE: 23c. If yes, outcor	as of programmy					
ROX	requires that the death certific been signed by the attending I should be detached for use as	Physician/M	in the past 12 months?	h 2 🗌 Fetal death 3 📃	Ectopic pregnancy Other (specify)	У		23d. Date of de Month	livery Day Year
ň	the a	ysic	1 Yes 2 No 4 Pregnan 9 Unknown 9 Unknown		Other (specify)				
J.	hat the ed by detac	٦	Part II. Other significant conditions contributing to deat	n but not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
<u>.</u>	iires t sign Id be	Completed by					1 🗆 `	Yes 2 XÍNo 3 □ F	robably 4 🗆 Unknown
ord	/ requ	lete					24a. Was a	an 24b. Were au	itopsy findings available
ပ္ မ	e has	mo						rmed2 death?	completion of cause of
Vital Records,	an: TI tifficat tor, pa	Be C	25. Was case referred to medical		26. Pla	ce of Death	1 L Yes Check only one)	2 No 1 ☐ Ye	s 2 No
	ysici is cer direc	일	examiner? 1 X Yes 2 No Hospital: 1 Inp	atient 2 KER/Outpatien	t 3 DOA Othe	r: 4 🗆 Nursii	na Home 5 🗆 Resid	ence 6 Other (Spec	cifv)
0	ng Ph ter th neral		27. Manner of Death Natural 5 Pending 28a. Date of light (Month, I		28c. Injury work	at		ow injury occurred	
on	endir eath. or: Af he fu	lica 	2 Accident Investigation	, , , , , , , , , , , , , , , , , , , ,		Yes 2 □ No)		
DIVISION OF	fer d	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of building,	njury - At home, farm, stre etc. (Specify)	et, factory, office		28f. Location (S City or Tow	treet and Number or Ru n. State)	ıral Route Number,
בֿ	oital o							· _ ·	
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Medical	29a. Certifier (Check Check 2 Medical Examiner: On the basis of	f examination and/or investi	gation, in my opinio	n, death occur	red at the time, date a	nd place, and due to the	cause(s) and manner stated.
	o the	Σ	only one) 3 Certifying Nurse Practioner: To the 29b. Signature and title of certifier	ne pest of my knowledge, d	eath occurred at the 29c. License			e cause(s) and manner as 29d. Date signed (Mont	
	r s F o		to tedalo	MD	70	65	2695	11-26-	-2010
	M	ŀ	30. Name and address of person who completed cause o	i death (Item 23a) (Type Pi	rint)			11 010	0010
	/		OMOLARA OXFDELE 811			D LAH	HAM MO	20706	
	Stat	е	31. Date filed (Month, Day, Year) 32. Regis	trar's Signature			-		
	Registra		NOV3 0 2010 Cenera .	BRUKE					

DHMH 17 Rev 7/2009

WADDILL , NOIAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 24, 2010 0230 A M Charles W. West 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Worcester Berlin 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Months Hours 4-20-1919 Delaware 221-18-8417 91 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Delaware Sussex Frankford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32918 Jones Road 19945 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Forces Black, White, etc. 1 X Never Married 2 Married Yes 2 X No If Yes, Give 1 Yes 2 No Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond E. West Bernice Lynch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard E. West/ Nephew 32464 Omar Rd, Frankford, DE. 19945 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗀 Removal from State George's Cemetery 11-30-2010 Frankford, Delaware 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Melson Funeral Services, Ltd 43 Thatcher Street, Frankford, DE. 19945 Exer the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a cons purnce of)

Physician/ Medical Examiner

attending physician and

signed by the atte

certificate be

P.O.

Vital Records,

600

Physician/

Medical

Director

Funeral

ð

Completed

Be

ဂ္

Examiner

Physician/Medical

ð

Be

မှ

Examiner

Funeral

Director

with the Maryland

Baltimore, Maryland 21215-0036

0520

0/

Should be filed with and Mental Hygien 7 is marked other the

and 2 should be Health and Meritem 27 is mark

permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr

ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at

Sequentially list conditions, n any, reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last

23b. Was decedent pregnant

in the past 12 months?
1 ☐ Yes 2 ☐ No

Due to (or as a consequence of):

23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant : Pregnant at time of death

23d. Date of delivery Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death?

24

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

determined

1 🗆 Yes	2 🗌 No	3 🏻 Pro	bably	4 Unknov
a. Was an autopsy performed?	- 1	Were auto prior to co death? 1 Yes		dings available on of cause of No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

Natural Accident

2 Accident
3 Suicide
4 Homicide

29a, Certifier

1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 5 Pending Investigation 6 Could not be

Hospital:

28b. Time of injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number. City or Town, State)

(Check 2 Medical Examiner: On the basis	1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
9b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)							

D56307

29d. Date signed (Month, Day, Year) November 24, 2010

BAID

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica

State Registrar ompleted cause of death (Item 23a) (Type, Print)
MD, 9733 Healthway Drive, Berlin, MD 21811

			For State	State of M	aryland	_	rtment o			/lental Hy	2	nın	30	257
			Registrar 1. Decedent's Name (First, Middle, La	nst)		Oei	incate (or Dea	2011	2. Date of De	Reg. No.	010	2 Tim	e of Death
	Physicia		Sarah Purnell V	Thite						Month Novem	ber 2	6 201	0 1.	35 P ^M
	Medic Examir		4a. Facility Name (if not institution, giv				4b. City, Tov	vn, or Loca	ation of Death	IIIO V CIIII	4c. Co	unty of Death	9 1 .	
	1		Berlin Nursing &	Rehabilita	ation		Berli	n			Word	cester		
	Funeral					st birthday)	If Under 1 Months D		Under 24 Hrs. ours Min.	8. Date of Bir	th av Year)	9. Birth	place (Sta	te or Foreign
	Director		5/8-50-42/6	T I M Z XZ F	95 	Yrs.		-,-		3/13/1	915	Dela	aware	
	and show d at	ا _ة	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	ation						10d. Inside	City Limits
	laryla 3a-f s ified	ect	MD Worcest	er	Ber:	lin								Yes 2 No
	or 28	Funeral Director	10e. Street and Number				10f. Zip Co	ode			10g. Citizen	of What Cou	ntry?	
	with s 23a ust b	era	9715 Healthway Dr	ive			2181	1			USA	A		
	death item		11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	. 13. W	as Decedent	of Hispan	nic Origin? (Spe	cify Yes or No- Rican, etc.)	14.	Race - Ameri		
36	after I', or kamir	d b	1 Never Married 2 Married	1 Yes 2 I	≬ Vo		☐ Yes 2 ☐			1110411, 010.)		Black, White, c <i>ify:</i> Wh:		
8	atura cal E	Completed	₩Widowed 4 ☐ Divorced	Year or Dates.			ent's Usual O							
15	72 h an "n: Medi	E E	(Specify only highest g	rade completed)	- 11	(Give k		one during	g most of work	ng	16b. Kind (of Business Ir	dustry	
21215-0036	withir giene er the		Elementary/Seconday (0-12)	College (1-4 or 9	p+)	Teac		,			Educa	ation		
ng 10	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notifiled at	Be	17. Father's Name (First, Middle, Last)					- 1		e (First, Middle,		,		
ah ya ı	ld be Ment larke atic e	욘	Col. Harry Selby	Purnel1				E1	lizabet	h Kenly	Spend	cer		
Sarah P Maryland	nd 2 should be filed within 72 hours after death with the Maryland saith and Mental Hyglene. In 27 is marked other than "natural", or items 23a or 28a-f sho ar traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Edward White/Son	Type, Print)		19b. Mailing 2 Bro	g Address <i>(St</i> okva11	reet and N ey Dr	Number or Rura r., Roc	Route Numbe hester,	er, City or Tow NY 14	n, State, Zip 4624	Code)	
White, Baltimore,	permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Special Contents)		ce	ace of Dispos metery, crem	atory or other	r place)	- 1	Oate 0/2010		on - City or T	own, State	
راہ] alt i	rmit. F partrr porta y inju		21. Signature of Furieral Service Jacer	**	1500					bage Fu				
<u> </u>	9 9 E 8 8		M. True Qu	ubale		-				rlin, N		11		
		15-010	23a. Part 1. En er the disc se, or con shock, or high failure. List only	nplications that caused one cause on each line	the death	. Do not enter	the mode of	dying, suc	ch as cardiac c	r respiratory ar	rest,		Approxir	
· F	Physician/		Immediate Cause (Final disease or condition	Faile	ne	to -	thri	le					Onset ar	
	Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):							7.00	
		ē	Sequentially list conditions,	b. anor	ekla									
	ed nsit	E.	cause. Enter Underlying Cause (Disease or iinjury) P m 0	1	tan	No	60A 0	nta					
	xecut n and al-trar	Exa	that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):	- 000	<u> </u>	190			-		-
09	ate be executed bhysician and the burial-transit	dical Examiner		d.										
976	ificate ig phy as th	Med	IF FEMALE:											
ő ×	n cert tendir r use	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth	of pregnan 2 Fetal	cy death 3 🗆	Ectopic pred	ınancv			23d.	Date of deliv	ery	
Bo	deat the at	/sici	1 Yes 2 XNo	4 ☐ Pregnant a 9 ☐ Unknown	t time of de	eath 5	Other (specif	fy)				Month	Day	Year
P.O. Box 687	at the d by letach	Completed by Physician/Me	Part II. Other significant conditions	contributing to death b	ut not resu	Iting in the un	derlying caus	se given in	Part I.	23e Did to	obacco use c	ontribute to t	ne cause o	f death?
G,	res th signe d be c	d b		, ,		•	,,,,,,	3			_	o 3 🗆 Pro		
ord	requ	lete								24a, Was		lb. Were auto		
မိ	e law e has ge 2	μğ								autor	osy ermed?	prior to co death?	mpletion o	f cause of
<u>~</u>	in: Th	Be C	25. Was case referred to medical				2	6. Place of	f Death (Check		2X No	1 🗆 Yes	2 L No	
Vita	ysicia is cer direct	To B	examiner? 1 ☐ Yes 2 X No	Hospital:	ent 2 🗆 E	R/Outpatient		Other: _		me 5 🗆 Resid	dence 6 🗆 (Other (Specifi	d	
of	ng Ph ter thi neral	te:	27. Manner of Death 1	28a. Date of inju (Month, Day		28b. Time of injury	28c.	Injury at work?		28d. Describe h				
ion	eath. eath. or: Af the fu	ilica	1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not !	n		,,		1 Yes	2 🗆 No					
Division of Vital Records,	or Att	Certificate:	4 Homicide determined	28e. Place of Inju building, etc	iry - At hom (Specify)	ne, farm, stree	et, factory, off	ice		28f. Location (S City or Tow		mber or Rura	Route Nu	mber,
	pital ours a eral [filled	cal	29a. Certifier 1 Certifying Phy	sician: To the best of	my knoudo	dae deeth ee	ourad at the	time data	and sizes an	1 -1 1 1	(-)			
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending pi completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director.	Medical	(Check 2 L Medical Exam	iner: On the basis of ex Practioner: To the	kamination a	and/or investig	gation, in my c	pinion, dea	ath occurred at	the time, date a	nd place, and	due to the ca	use(s) and i	manner stated.
	То th withir сопр	2	29b. Signature/and title of certifier	7				ense numb				ned (Month,		
			> Terme =	savage (1	R 13!	5131		Nove	mber	29,	2010
	108	-	30. Name and address of person who Pennie Savage,	completed cause of de	eath (Item 2	23a) (Type, Pri Iealth	nt)	Or, 1	Berlin	, MD	21811			
	Stat Registra	e	31. Date filed (Month, Day, Year)	32. Registra				-						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of IVI	arylan	•	artment of F tificate of L		Mental Hy	giene Reg. N	2010	39268
Dhu		. ,	Decedent's Name (First, Midd	dle, Last)				Journ	2. Date of De	eath	0,4 0 1 4	3. Time of Death
Phys M	sıcıaı edic			RALPH LLOYD	WISE	R			Month NOV	22	2010 Year	7:20 P M
Exa	ımine	er	4a. Facility Name (if not institution		CATOLETO.			r Location of Death	1	40	c. County of Death	
Fune	aral		5. Social Security Number	AL MEDICAL CI		ast birthday)	BET If Under 1 Year	HESDA I If Under 24 Hrs.	8. Date of Bir	th	MONTGOI	MERY uplace (State or Foreign
Direc			215-18-9474	1 🏿 M 2 🗆 F	100		Months Days	Hours Min.	June 3	ay, Year)	Cour	ntry)
pu mou	Ħ	٦	Usual Residence of Decedent 10a. State 10b. Count	ty	10c. City	, Town or Lo	cation			-		10d. Inside City Limits
lanykar Sa-f sl	mea	Director	MD Moi					_				1 ☐ Yes 2 ♣ No
the N	e no		10e. Street and Number	ntgomery		Gaiti	10f. Zip Code	9	T	10g. C	itizen of What Cou	ntry?
h with		Funeral	419 Russel	l Avenue, #	509		208	77		US	A	
r deat or iten			11. Marital Status1 ☐ Never Married 2 ☐ Married	12. Was Decedent 8 Armed Forces?		6. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Americ Black, White,	
tural", o	EX	ed by	3 ★ Widowed 4 □ Divorce	If Van Chia	WWIJ	[1	☐ Yes 2 🗷 No	Specify:			Specify: Whi	te
2 hou "natu	in a	plet		lent's Education hest grade completed)	J		ent's Usual Occup		kina	16b. F	Kind of Business In	ndustry
ithin 7 ene. than	Specify: Spe								egal			
Id w ll Hygi other		Be	17. Father's Name (First, Middle,				2 W y C L	18. Mother's Nan	ne (First, Middle,			<u>-</u>
yidi d be f Menta arked		Floyd J. Wiser Alice Edith Hoc 19a. Informant's Name/Relationship (Type, Print) - Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town								Hook		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any initing or other than "natural", or items 23a or 28a-f show any initing or other than the Anglind Expansion must be partially as a part in the property.			19a. Informant's Name/Relation C. Lawrence		ther	19D. Mailli	g Address (Street a Wake Di	and Number or Ru rive, K	ral Route Numbe ensin g	er, City oi t o n	r Town, State, Zip , M D 2 0	Code) 895
Page 1 ar tment of He tant: If iten				n 3 Removal from State	20b. Pl	lace of Dispos emetery, crem Lingto	sition (Name of natory or other place on Nat	Fe Fe	bil ⁹ ,		ocation - City or To	
mit. Pa	e e	1	4 ☐ Donation 5 ☐ Other 21. Si rature of Funeral Service			Ceme	etery	<u> </u>			<u>lington</u> al Home	
	once		> Tychard L	fales		5 (00 Unive	ersity	Bl vd.	W.,	Silver	Spring,M
				or complications that caused tonly one cause on each line	I the death	. Do not ente	r the mode of dying	g, such as cardiac	or respiratory an	rest,		Approximate Interval Between
Physicia Medi			Immediate Cause (Final disease or condition resulting in death)	a. SEPS								Onset and Death
Exami				Due to (or as a	a conseque	ence or):						
- =	n.	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a conseque	ence of):						
ecutec and trans	5	Examiner	that initiated events c								- 1	
icate be executed physician and sthe burial-transit		ca	, , , , , , , , , , , , , , , , , , ,	d								
		Med	IF FEMALE:	_ u.								
atth certific attending			23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth	2 Fetal	death 3	Ectopic pregnanc	y			23d. Date of deliv	-
Attending Physician: The law requires that the death certificate and each. Sector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a		Physic	1 Yes 2 No 9 Unknown	4 ∐ Pregnant a 9 ☐ Unknown	t time of de	eath 5 ∟	Other (specify)				Month	Day Year
s that t igned b be deta		by P	Part II. Other significant condit	ions contributing to death b	ut not resu	ılting in the ur	nderlying cause giv	en in Part I.	23e. Did to	obacco (use contribute to th	ne cause of death?
requires been signatured									1 🗆 '	Yes 2	INO 3 ☐ Pro	bably 4 ☐ Unknown
law re has by ge 2 sh		Completed							24a, Was autop		24b. Were auto prior to co death?	psy findings available impletion of cause of
in: The la ificate ha or, page?		_	25. Was case referred to medica	ı I			26 Pla	ace of Death (Chec	1 X Yes			2 😾 No
ysician: ysician: is certific director,	1	lo Be	examiner? 1 ☐ Yes 2 ☐XNo	Hospital:	ent 2 🗆 E	ER/Outpatient	Othe	er:		dence f	3 ☐ Other (Specify	- · · · · · · · · · · · · · · · · · · ·
ding Ph th. After th funeral			27. Manner of Death 1 ☑ Natural 5 ☐ Pend	28a. Date of injui		28b. Time of injury	28c. Injury work	at	28d. Describe h			/
ttendideath death stor: A		Certificate:	2 Accident Invest 3 Suicide 6 Could	tigation d not be	n. At ban	ma farm atra		Yes 2 No	2011 11 10			
alor A safter s af Direct			4 ☐ Homicide deten	mined 20e. Flace of Inju		ne, iami, sire	et, factory, office	ļ	City or Tow		d Number or Rural)	Houte Number,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Completed filled in by the funeral	:	Medical	(Check 2 L Medical	g Physician: To the best of examiner: On the basis of examiner: To the	camination	and/or investi	aation, in my opinio	 n. death occurred a 	t the time, date a	nd place	and due to the car	use(s) and manner stated.
To the To the	ا ا		29b. Signature and title of certific				29c. License			due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)		
12+	1				> PH	YSTUED	رم 0102	202648 (NI		,2010
-		ſ	30. Name and address of person			_	int)		AL NAVA			NTER
	State		JEFFREY J. L. 31. Date filed (Month, Day, Year)		USN r's Signatu	ite.	20	BETHES	DA MD 20	100Y	·	
Regi			MOA 8 8	2010		ire fav						

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State RegistraMEND#20bperFH, 12/7/10, BMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11-20-2010 0850 Robert Lee Wesley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 🔽 M 2 🗆 F $0^{(1)} - 2^{(1)} + 1^{(2)} + 1^{($ Washington, DC Director 577-54-8310 69 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at within 72 hours after death with the Maryland Director 1 🌠 Yes 2 🗌 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20002 U.S.A. 1844 Central Place N.E. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or δ 1 Never Married 2 X Married 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify:Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Custodian Office Building 11th Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Wesley Mattie Dunston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1844 Central Pl. N.E. Washington, DC 20002 Mary F. Marshall (Wife) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【▼ Cremation 3 ☐ Removal from State Beltsville, MD 4 Donation 5 Other (Specify) Chesapeake Crematory Signature of Funeral Service Litensee 22. Name and Address of Facilit W.H. Bacon Funeral Home, Tucial 3447 14th St. N.W. Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a Yes 2 No g Unknown P.O. I Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď Records, To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 Yes 2 No Yes 2 L Division of Vital director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Impatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 Natural 5 Pending 1 Tes 2 No М Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) License number 060 3 MI

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

MOA 2 9

MO

ymps.

Registrar's Signature

Universite

MO

20 903

Silver Sp

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:26 M Zon Norman Dale Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 1 M 2 🗆 F Director Yrs 212-88-8614 /26/1933 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 ☐ No <u> Maryland | Washington</u> Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17112 Reedy Parkway 21740 U.S.A 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) N/A College (1-4 or 5+) Sorter Human Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Norman Pau1 Will Frances Emma Swain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Lowery / Sister 708 W. Franklin St. Hagerstown Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 12/7/2010 Hagerstown Maryland . Signature of Funeral Service Licen 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland 21742 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complication Approximate Interval Between shock, or heart failure. List only one ca Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner enmone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and I for use as the burial-transit Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ate has been signed by the atterpage 2 should be detached for a in the past 12 months? Month Day Year Yes 2 No 1 Yes 2 L 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform After this certificate Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner 2 **₩**No Other: 1 Yes ၉ 1 Nanpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 ANatural 5 Pending work? 1 ☐ Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 opal Court Hazerstown, MD 21740 Wuscen Date filed (Month, Day, Year, State 2010 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 YOUNG a.k.a Sonja Sue Young 3:16 A M December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 X F Months Days Hours Min (Month, E Director 212-38-8956 Maryland 10 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 25 is marked other than "natural", or items 23a or 28a-f shouther traumatic event, the Medical Examiner must be notified at 10a, State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Frederick Jefferson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3311 Lander Road United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samuel D. Bovd Missouri Elizabeth Shank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darryl Young / Son 202 East K Street, Brunswick, Maryland 21716 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 s Department of F Important: If ite December 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Tremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) 6, 2010 Smithsburg Crematory Smithsburg, Maryland f Juneral Service Licenses Keeney and Address of Bastord PA Funeral Home. any. MO1473 106 E Church Street Frederick Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Preu monia disease or condition Medical resulting in death) Examiner mental Status Altered Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Examine Stroke To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months? Day Pregnant at time of death
Unknown Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [] Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No ျှ 1 ■ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛭 Natural 5 Pending injury Accident
Suicide 1 Tyes 2 🗆 No Investigation

Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a Certifier 🖭 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 714 51

400 W

r's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bruntel

2010

31. Date filed (Month, Day, Year)

13

FINIT

MDH67732

Frederick MD 21701

12/5

10

		1	For State Registrar	State of Maryland	-	irtment of F tificate of E			liene	Table of the second	39272
Phys	iciar	1/	1. Decedent's Name (First, Middle, Last)					2. Date of Deat	Day a	Year	3. Time of Death
Me	edica	ai .	Fredrick Melvin Zi 4a. Facility Name (if not institution, give str			4h City Town or	Location of Death	//ovent	er de	<i>2010</i> ty of Death	1 SospM
Exa	milate	şr	Washington County			Hagerst					n County
Fune				7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Nov . Day,	1	9. Birth	place (State or Foreign higan
d wo	62		Usual Residence of Decedent 10a. State 10b. County	100 City	Town or Loc	ention					10d. Inside City Limits
arylan a-f sh fied a		900	Maryland Washingto		erstow						1 Yes 2X No
the Ma or 28		<u></u>	10e. Street and Number	ii dodiio) iidg	CLUCO	10f. Zip Code			10g. Citizen of	f What Cou	
s 23a		Funeral Director	1914 Applewood Dr	•		21740			U.S.	Α.	
partition (e), Maryliania Z.I.Z.13-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		<u>ا چ</u>	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		Vas Decedent of Hi Yes, specify Cubar ☐ Yes 2X No	spanic Origin? (Spe n, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)		ace - Americ ack, White, fy: Wh	etc.
2 hou "natu		Completed	15, Decedent's Educ (Specify only highest grade	(Give k	ent's Usual Occupa ind of work done d	ation uring most of worki	ng	16b. Kind of	Business In	dustry	
ithin 7		ខ្ញុំ	Elementary/Seconday (0-12)	College (1-4 or 5+)		NOT use retired) pendent. T	nsurance	Agent.	Self E	mplov	ed
be filed wental Hygi			17. Father's Name (First, Middle, Last)				18. Mother's Name				
yidi Ild be Menta Iarkec		욘	Fredrick Enos Zieg	······································			Irma Za	hnow Zi	egler		
, Mal nd 2 shou saith and n 27 is m er traum			19a. Informant's Name/Relationship (Type Barbara Ziegler-wi	,		-	nd Number or Rura d Dr. Hag		-		Code)
o = iter of of the of of the			20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3 ☐ Re	emoval from State ce	metery, crem	sition (Name of atory or other place	9)		20c. Location	•	
Dallillor Dermit. Page 1 Department of Important; If it in in vorce			4 ☐ Donation 5 ☐ Other (Specify)	Smi			ory 12-1-				Maryland
Departing any i	ouce.		21. Signature of Funeral Service Licensee	Jaroni Sii	tes 13	31 Easte	^{s of Facility} Dou rn Blvd.	North H	agerst		
Physicia Medic	_		23a. Part 1. Enter the disease, or complete shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	mar	Na			est,		Approximate Interval Between Onset and Death
Examir				Due to (or as a conseque	ence of):	d. des	hele-				6 marsh
		iner	Sequentially list conditions, b. If any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	inee oi).		11:60	-		į.	6 months
ath certificate be executed attending physician and for use as the burial-transit		Examiner	Cause (Disease or iinjury that initiated events c. resulting in death) Last	Due to (or as a conseque	15/22v ence of):	ng m	debility multiforme				months
tte be e hysicia he buri]	edical	d.								
tificat ring ph			IF FEMALE:						- 1	- 1	
To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as		Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnan 1 Live Birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 🗌	Ectopic pregnance Other (specify)	У			ate of deliv	ery Day Year
do, T.O. quires that t en signed b		≥	Part II. Other significant conditions cont	ributing to death but not resu	lting in the ur	derlying cause give	en in Part I.				he cause of death?
The law requires ate has been signage 2 should b		Completed						24a. Was ai autops perforr 1 \square Yes	med?	. Were auto prior to co death? 1 \(\sum \) Yes	psy findings available mpletion of cause of 2 \square No
II OI VICAL INC. ding Physician: The la h. After this certificate ha funeral director, page	Į,	Be	25. Was case referred to medical examiner?	spital:			ce of Death (Check	only one)			
g Physic er this control	ŀ	<u>۵</u>	27. Manner of Death	1 Nnpatient 2 D	R/Outpatient	3 ☐ DOA Othe 28c. Injury	4 ☐ Nursing Ho	me 5 Reside)
nding ath. r: Afte		cate	1'Natural 5 Pending 2 Accident Investigation	(Month, Ďay, Year)	injury	work'	y [™] Yes 2 ☐ No	od. Describe no	w injury coour	ii cu	
al or Attendir s after death. Il Director: Af		Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (Sta City or Town		ber or Rura	l Route Number,
he Hospit in 24 hour he Funera		Medical	(Check 2 Medical Examine)	an: To the best of my knowle r: On the basis of examination Practioner: To the best of my	and/or investi	gation, in my opinio	n, death occurred at	the time, date an	d place, and di	ue to the ca	use(s) and manner stated.
To t		- 1	29b. Signature and title of certifier			29c. License	number 4996	2	9d. Date sign	ed (Month,	Day, Year) 20/0
3H-20	,		30. Name and address of person who com	pleted cause of death (Item 2	23a) (Type, Pr	appan	s Rel Bo	ronsber	o M	021	713
Regi	State stra	•	31. Date filed (Month Pay Year)	32. Registrar's Signatu	re · · · · · · · · · · · · · · · · · · ·	and I					

			For State	State of M	aryland / Dep			Mental Hy	giene	30273	
			Registrar 1. Decedent's Name (First, Middle, La	net)	Cei	rtificate of L	<i>Death</i>		Reg. No. 9 10 9 7 2 1 3		
	Physici		VERNON LEE ADAMS,	,				2. Date of Dea	^{Day} 2010 ^{ar}	3. Time of Death 6:34PM M	
drawing	Medi Exami		4a. Facility Name (if not institution, giv			4b. City, Town, o	r Location of Dea		4c. County of Dea		
p-"			GILCHRIST CENTER	,			WSON	u	BALTIM		
7	Funeral	Г	Social Security Number 6.		e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hr		h 9. Bi	rthplace (State or Foreign	
ı.	Director		L 217-16-5474	XIXIM 2 □ F	86 Yrs.	Months Days	Hours Min	. (Month, Day	, Year) 1923 Ma	ountry) ryland	
	how at	٦	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation					
	arylar a-fs	ectc	Maryland Baltim	ore	issi oly, four or Es		more Cou	unty		10d. Inside City Limits 1 ☐ Yes 2√√ No	
	or 28	ä	10e. Street and Number			10f. Zip Code			10g. Citizen of What C		
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	9105 Carlisle Av	enue			21236		USA	ouritry ?	
	leath items er m	표	11. Marital Status	12. Was Decedent E		Nas Decedent of H	spanic Origin? (S	specify Yes or No-	14. Race - Ame	erican Indian,	
36	after of ", or amin	þ	1 Never Married 2 Married	Armed Forces? 1x Yes 2 If Yes, Give	No WW 17	f Yes, specify Cuba □ Yes 2 🕱 No		to Rican, etc.)	Black, Whi	te, etc.	
Ö	ours a	Completed	3xxWidowed 4 □ Divorced	Year or Dates.					Specify: Wh	ite	
15	72 h In "na Aedic	du	15. Decedent's I (Specify only highest g.	rade completed)	(Give I	lent's Usual Occup kind of work done o O NOT use retired)	ation <i>luring most of w</i> o	rking	16b. Kind of Business	Industry	
212	within giene. er tha		Elementary/Seconday (0-12)	College (1-4 or 5	+)	et Metal	Worker		Edgewood A	rsenal	
br	filed val Hyg	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, i		2001142	
ylaı	Menta narked	2	Vernon Lee Adams				Florenc	ce Melsor	Webster		
, Mai	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	1	19a. Informant's Name/Relationship (1 Terry Lynn Adams Fit		19b. Mailin	g Address (Street a	ind Number or Ri Ct. Ba	ural Route Number, ltimore,	, City or Town, State, Zi Md. 21236	o Code)	
Baltimore, Maryland 21215-0036	e ± t e		20a. Method of Disposition X⊠ Burial 2 ☐ Cremation 3 ☐		20b. Place of Disposemetery, crem	natory or other place	e) DI 12	Date	20c. Location - City or		
ä	per nit. Pag Der artmen Important: any injury once,		4 Donation 5 Other (Special Signature of Funeral Service Licen	**		. Name and Addres	1		Baltimore, Ol Belair F		
m	an Dear	11.	1 Bother 195	sence		assahn Fu			ltimore, Mo		
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused	the death. Do not ente	r the mode of dying	, such as cardiad	or respiratory arre	est,	Approximate	
	hysician/	i y	Immediate Cause (Final disease or condition	ASOL	vation	Drew	mia			Interval Between Onset and Death	
3	Medical Examiner		resulting in death)	Due to (r as a	consequence of):	V			1 5	0,712	
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):	cutesto	my tub	e seca	(ngs	Days	
7	ited ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	Dun	ento m	milter	ulans	_		4-05	
10	execu an and rial-tra	i Ex	that initiated events resulting in death) Last	Due to (or as a	consequence of):		0			f	
09	law requires that the death certificate be executed ras been signed by the attending physician and a 2 should be detached for use as the burial-transit	edical		d							
687	irtifica ling pl e as t	/Me	IF FEMALE:	00.16							
Box (ath certific attending p	ian,	23b. Was decedent pregnant in the past 12 months?		Petal death 3		,		23d. Date of de	*	
m	the deached	Physician/M	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death 5 🗆	Other (specify)			Month	Day Year	
P.O.	requires that the de been signed by the should be detached	by Pi	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the ur	nderlying cause give	en in Part I.	23e. Did tol	pacco use contribute to	the cause of death?	
Š,	uires n sigr uld be							1 🗆 Ye	es 2 🗆 No 3 🗆 Pi	robably 4 nknown	
000	aw req as bee 2 shor	plet						24a. Was ar		topsy findings available	
Records,		Completed						autops perform	med? prior to death?	completion of cause of	
<u>.</u>	lysician: The lis certificate director, pag	Be	25. Was case referred to medical examiner?			26. Pla	ce of Death (Che		Z DA NO T T TES	2 🗆 No	
>	hysic this or	은	1 🗆 Yes 2 XNo		nt 2 🗆 ER/Outpatient	3 DOA Other	: _4	lome 5 Reside	ence 6 Sther (Speci	TO MOSPILLE	
ָם ס	ding Ph th. After th funeral	Certificate:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day,		28c. Injury work?		28d. Describe ho	w injury occurred		
015	death death stor: / the /	<u>i</u>	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		NI C		es 2 🗆 No				
Division of Vital	tal or A rs after al Director ed in b		4 L Homicide determined	building, etc.	y - At home, farm, stree (Specify)	эт, тастогу, опісе		28f. Location (Str City or Town	reet and Number or Rur , State)	al Route Number,	
	or the nospiral or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Medical	(Uneck 2 L. Medical Exami	ner: On the basis of exa	mination and/or investig	nation in my coinion	death occurred	at the time date on	se(s) and manner as sta d place, and due to the c		
	within To the comp	— r	29b. Signature and title of certifier	e Fractioner: To the b	est of my knowledge, de	29c. License	number	2:	cause(s) and manner as	Dav. Year)	
			Marl	un		Type, Print) Chence ST M SON M				8 Z200	
	1/40	-	30. Name and address of person who c	ompleted cause of dea		nt) O		<u> </u>	, 50511190		
	State		31. Date filed (Month, Day, Year)	ARUES /	W) 6701	N. Cha	Mes ST	- POW SO	NM		
	Registra	_	DEC 1 4 2010	Lenn	1. back						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2:30 0 2010 MINDLYA **ABRAMOVA** Decembe /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner tation almuore bardens Nuring and Nevani SMOVE If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □X Months Days Hours Director 212-41-1126 10/11/1923 UKRAINE Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2√ No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 7920 SCOTTS LEVEL ROAD 21208 UKRAINE Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2[XNo Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify. 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w h and Mental Hygier 7 is marked other th 4 BOOKKEEPER GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ew 2 **FABISHENKO** MALKA UNOBTAINABLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SIMON ABRAMOV/STEP-SON 6 DINADEN CIRCLE, BALTIMORE, MD21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 □Removal from State 4 Donation 5 Other (Specify) ARLINGTON CHIZUK AMUNO 12/12/2010 BALTIMORE, MD Signature of eral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part: Enter the disease, or complications that caused the distance ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** U /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine that initiated events resulting in death) Last burial-trar Records, P.O. Box 68760,[™] Due to (or as a consequence of) physician Physician/Medical attending pt I for use as tl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autops perforn certificate Division or Vital 1∐ Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner' Other: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient Certification: To 3 DOA this Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Matural 2 Accident * atural Injury 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 410

State Registrar

J

Abramovae

Mindlya

level Ad Raltimore

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ P M Buchanan 2010 Mae Dec Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll Dove House Hospice Westminster 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Oct. 14 Months Hours Min. North Carolina 1 M 2 K F Yrs. .941 69 **Director** 215-40-0634 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medic." Examiner must be notified at Director 1 Yes 2 X No MD Carroll Finksburg 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3233 Murray Road Lot 24 21048 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental H မ Flora Woody Forbes Cleamon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 3233 Murray Rd., Lot 24, Finksburg, MD 21048 James Buchanan / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/14/10 Baltimore, Maryland Metro Crematory Inc Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, 299 Frederick Road Baltimore, Inc. Maryland 21228 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. val Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) neumonia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any learning to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): death certificate be executed attending physician and for use as the burial-transit Vertebral that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day signed by the a ld be detached for g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Wes 2 □ No 3 □ Probably 4 □ Unknown of Vital Records, Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No Yes 2 X No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, examiner? Hospital: Other: 2 1 X Yes 2 🗌 No 4 Nursing Home 5 Residence 6 Yother (Specify) 1 Inpatient 2 ER/Outpatient 3 I this . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director; After 1 Natural 2 Accident UNITED Y 5 Pending Division Oct 31, 2010 1 ☐ Yes 2 ☑ No Legs gare out Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3233 Morray Road, Lot24 Finks bu 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined home Medical 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature and title of certifie 12-13-2010 400062558 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster Md 21157 MD, 410 Malcolm Kermen, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 9:23 AM William Thomas Byrd DECEMBERIO 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A BALTIMORE AGNES HOSPITAL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F 62 1948 Director 465-72-4131 Jan 15, Mississippi Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show th and Mental Hygjene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exyminationals to rolling at 1 ☐ Yes 2 X No Director Maryland Baltimore Catonsville the 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21228 55 Wade Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or iten any Injury or other traumatic event, the Medical Examinations. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Shipping Industry 8 Longshoreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William T. Byrd Bertie K. Stephens 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9122 B Barton Houston, TX 77075 Arlie J. Sumrall, Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 12/13/10 Baltimore, Maryland 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licensee Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END STAGE LIVER DISCAVE **Physician** WEEKS /Medical Due to (or as a consequence of): Examiner EARS IRRHOSIS OF INER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit EAR HEPATITIS C Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed res 2 2 No 1 ☐ Yes 1 □Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MEDICAL RESIDENT DECEMBER 10, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE NIRAN PATEL 900 S CATON

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Burgess Murie 11:30 AM -2010 Dec 12 /Medical 4c. County of Death 4a. Facifity Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner , MD Randallstown Centar Randallstown Baltimore Genesis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🕅 F Director 219-52-5881 62 1/9/1948 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Baltimore Sparrows Point 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21219 S. A. Funeral 2417 Lodge Farm Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify Specify: <u>ک</u> 3 XWidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 10 Bingo Hall Housekeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event Be <u>Marie H. Brecht</u> Muriel W. Canatella 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1754 Country Road York, PA 17408 Beverly Scopel (Sister) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 12/14 2010 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Memorial Gard. Middle River, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Fastern Avenue Essex, MD 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. cardio vascular Immediate Cause (Final disease or condition resulting in death) Aterosclerotic **Physician** /Medical Due to (or as a consequence of) Examiner Diabetes Ecquentially list curvitions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hypertensis Due to (or as a consequence of): burial-transi P.O. Box 68760, Physician/Medical stage the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 XNo Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>م</u> 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy perform 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 X No Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. e Funeral Director; After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier , MO 086 Dec - 13 - 2010 D 71493 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Farah Bozorgi 9109 Liberty Road Randallstown, MD 21133 MD 31. Date filed (Month, Day, Year) **DEC 1 4 2010** State

DHMH 17 Rev 1/2001

Registrar

Bryan Golster

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

NK UNK		1- For State Registrar	ate of Marylan		tment of ficate of		Mental I		eg. No.	1 U 0727		
Physic ledical Exam		Decedent's Name (First, Middl				nth Day Year r 10, 2010	2305 nrs					
		4a. Facility Name (if not institution, give street and number) 5109 Montgomery Road			b. City, Town, or Location of Death Ellicott City			4c. County of Death Howard				
Funeral Director		5. Social Security Number 214-29-4282	6. Sex 7 1 M 2 F	Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hi Hours Mi	n v	th(MM/DD/YYYY) / 11, 1990	Birthplace (State or Foreign Country)		
Maryland 28a-f show any <u>d at once.</u>	٦	Usual Residence of Decedent 10a. State 10b. County MD	Howard	10c. City, To	own or Location	on	Elkridge	e		10d. Inside City Limits 1 Yes 2 No		
ith the Maryland 23a or 28a-f sho notified at once.	Il Director	10e. Street and Number 5027 Landing Rd.				10f. Zip Code	21075		10g. Citizen of What Country? U.S.A.			
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygier Mental Hygier 27 is marked other than "natural", or items 23a or 28a-f shu zimatic event, the Medical Examiner must be notified at once	by Funer	1 Never Married 2 Married Armed Forces? If Y 1 Yes 2 No 3 Widowed 4 Divorced or Dates:			1	S Decedent of Hispanic Origin? (Specify Yes or No- es, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 X No specify:			White,	T WALLY		
5-0036 led within 72 hour Hygiene. other than "natu	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+) 1 Student					tired)	iness/Industry Education			
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be	17. Father's Name (First, Middle, Last) Jeffrey Scott Bolster					18. Mother's Name (First, Middle, Maiden Surname) Michelle Olet Brotzman Street and Number or Rural Route Number, City or Town, State, Zip O					
MD 2 nd 2 shoul alth and N m 27 is m	은	19a. Informant's Name/Relationsh Jeffrey Bolster	Father		5027	Landing Rd.	. Elkriage,	, MD 21075				
Baltimore, MC permit. Pages I and 2 s Department of Health at Important: If item 27 injury or other traum.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Sp.	ecify:	State crer	natory or othe Atlantic C	rematory, LL0	C De	Date ec 13, 2010	GI	City or Town, State en Burnie, MD		
		21./Signature of Fuoral Tervico	en Bright	MORGE	3 22. Na	^{ag} ମିକ୍ଟିନ୍ଟ୍ରନ 3871 Old	ferิล์เป็Mome Columbia f	P.A. ike Ellicott	City, MD 2104	13		
Physician Medical Examiner		23a. Raxt I. Enter the sisease, or of failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	on each line. a. Head Injuries Due to (or as a con	Complicated					est, shock, or hear	t Approximate Interval Between Onset and Death		
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or se a con									
be executed ician and unial - transit	al Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.										
60, ite be exe hysician a e burial -	Medical	UNPENDED IF FEMALE:	AMENDED	ome of pregnance	CV				Table Date of de	the second		
Division of Vital Records, P.O. Box 68760, To the Hospital or Atteoding Physician: The law requires that the death certificate be execut within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tra	Physician/Me	23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23d. Date of delivery Month Date of Death Sectopic pregnancy 1 Charles Security 9 Unknown							Day Year			
ires that the signed by I be detach	Š	Part II. Other significant condition	ons contributing to dea	ath but not result	ting in the un	derlying cause give	en in Part I.		pacco use contribu	te to the cause of death? Probably 4 Unknown		
Division of Vital Records, P.O. Boy rat of the deal rat or Attending Physician: The law requires that the deal rs after deam. **I Director: After this certificate has been signed by the att led in by the fameral director, page 2 should be detached for	Completed	75 M						24a Was a autops perform 1 ✓ Yes 2	y prid ned? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 No		
Vital nysician this cert	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpat	tient 2 ER/	/Outpatient	104	Death (Check		Residence 6	Other: Scene		
Division of Vital Rec To the Hospital or Atteoding Physician: The I within 24 hours after death. To the Fuoeral Director: After this certificate I completely filled in by the funeral director, page	ation: T	27 Manager of Death										
Divisior To the Hospital or Atteod within 24 hours after death To the Fuorral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Local Street (
To the Hospital within 24 hours: To the Fuoeral completely filled	Medical	(Check only one) 2 Medical Exam	eck only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
		Mlan Bi	and UMA	À		O.C.M.			December 11	(Month, Day, Year)		
V		30. Name and address of person w Melissa Brassell, MD	Assistant Medica	al Examiner		nn Street, Bali	timore, MD	21201				
St Regist		31. Date filed (Month, Day Year)	Server 32. Registra	ar Signature	Mal							

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Methember Payl1 12:53 Physician/ 2010 Robert Burgess Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Frederick 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Memorial Hospital Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 XM 2 F (Month, Day Year) 6/1/1932 217-28-6055 Director 78 MD Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Manyland anet of Health and Mental Hygiene. ant. If item 27 is marked outher than "natural", or items 23a or 28a-f sho ant. If item 27 is marked outher than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Orrtanna Adams 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1700 Orrtanna Rd. 17353 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 No Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NIH Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lyda Kelly Thurmond Burgess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy May Burgess/Wife 1700 Orrtanna Rd., Orrtanna, PA 17353 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit, Page 1
Department of Important: If it any injury or o 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) 12/16/2010 Lake View Mem. Park Sykesville, MD Signature of Funeral Service License ²²Burrier-Gueen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Probable myocardia disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any modified to cause. Enter Underlying Examiner Due to for as a consequence of Division of Vital Records, P.O. Box 68760

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 1 No 1 ☐ Inpatient 2 🗷 ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. 28d. Describe how injury occurred Natural
Accident
Suicide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi The Certifying Projection: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12/13

Registrar DHMH 17 Rev 7/2009

State

400

744

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Casiano

Manuel

31. Date filed (Month, Day, Year)

D0035267

mo

10-09411 Timothy Brown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Di-		Registrar	of Maryland /	Departm Certific	nent of cate of	Health and Death	Menta	ll Hygiene	Reg. N	lo.		2 8
Physi Medical Exa	cıar min								Date of Death 3. Tin			Time of Death
2	TIMOTHY BROWN 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Local				. Tell 12-	Decem	December 7, 2010					
		St. Agnes Hospital	,			Baltimore	ocation of E	Death		4c. County of	Death	
Funera	al	Social Security Number 6. 3	Sex 7. Age	(In yrs. last bir	thday)	If Under 1 Year	If Under 2	4Hrs 8 Date o	f Birth/M	M/DD/YYYY)	O. Diethala	(0)
Directo	17		M 2 F	49	Yrs.	Months Days		Min			Foreign	
Å.	1	Usual Residence of Decedent						June	22,	1961	Country) MD
ow any		10a. State 10b. County	1	0c. City, Town	or Location						100	I. Inside City Lim
yland P-f sh	غ ا	MD				BALTIMOR	EΕ					X Yes 2
eath with the Maryland items 23a or 28a-f shows to be notified at once	į	10e. Street and Number	10f. Zip Code					10g. C	itizen of Wha	t Country?		
ith th	5	2109 TUCKER LAND				21207			١,	U.S.A.		
5-0036 led within 72 hours after death with the Maryland Hygene. other than "matural", or Items 23a or 28a-f sho	Funeral Director	1 X Never Married 2 Married	12. Was Decedent E- Armed Forces?	ver in U.S.	13. Was E	ecedent of Hispa specify Cuban, M	nic Origin?	(Specify Yes or	No-	14. Race - /	American I	ndian, Black,
fier d	II.		1 Yes 2 1	No				orto Ricari, etc.)		White,	etc.	
ours a atura	Ş	45 Day 1 11 5		eted) 16a [es 2 X No s		-6 -1			BLACK	
6 172 h Cal Ea	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	-	during most	of working life. Do	O NOT use	of work done retired)	16b.	Kind of Busin	ness/Indust	ry
within er the	8	12		i (l]	DISABLE			Ι,	N/A		
- ₩ □ ₽ ±	ပြွ	1					Mother's Na	me (First, Middle				
2121 Jid be fi Mental J	To Be					N	ORMA 1	MAE BROW	IN			
O 8 5 2 5						ldress (Street ar	nd Number	or Rural Route N	umber, C			
C, D I and Health item	nin	GWENDOLYN EVANS/S 20a. Method of Disposition		20b. Place of	WOOD'	THORNE C'	I. AP	I 2 OWIN	IGS M	ILLS,	1D211	17_
Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum.		1 X Burial 2 Cremation 3	Removal from State	cremato	ry or other p	olace)	ery,	Date	20c.	Location - Cit	y or Town,	State
altir nit. P artme sortar	1	4 Donation 5 Other Specify: 21. Signat regal Service I cen.	999	MT. ZIC	ON CEM	1ETERY	12-	-14-2010	BA	LTIMOF	RE, M	D
ii ii ii ii ii		MAN			ÍĽĽ	AM C. BI	SACHTXT (COMMENT	TT 7777			P.A.
Physician		23a. Part1. Enter the Sease, or complifailure. List only one cause on ea	cations that caused the	death. Do not	11206 enter the m	W. NORTH	AVE.	BALTIM	ORE.	MD 21	217	
√Medical ≛xaminer		Immediate Cause (Final disease a	Atheroscle	eortic	cardi	ovascula	r die	A25A	11651, 5110	ck, or neart		roximate Interva ween Onset and
		Or condition regulting in death	ue to (or as a conseque	ence of):		ubeulu	1 415	ease			_	Death
	-	Sequentially list conditions, b if any, leading to immediate										
	Ē	cause. Enter Underlying Cause (Disease or injury that initiated	ue to (or as a conseque	ence of):								
lsi ed	Examiner		ue to (or as a conseque	ence of):							+	
Box 68760, the death certificate be executed the attending physician and ed for use as the burial - transit		dd.									1	
60, ate be e hysicia e buria	Medical		AMENDEP, 27, pe	r ME g	910 12	2/22/10	\mathtt{TT}					
187 rtifica ing ph as the		23b. Was decedent pregnant in the	23c. If yes, outcome of	pregnancy	7				23d.	. Date of deliv	rery	
Box 687 e death certific the attending p ed for use as th	<u>Ş</u>	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time	of death 5	Other (ctopic pregr	nancy	'	Month	Day	Year
	Physician/		9 Unknown									
Division of Vital Records, P.O. Box 687 tal or Attending Physician: The law requires that the death certific is after death. al Director: After this certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the content of the content	<u>a</u>	Part II. Other significant conditions	ontributing to death but	not resulting in	the underl	ying cause given i	in Part I.	23e. Did t	obacco u	se contribute	to the caus	se of death?
ords, w require								1 Ye	s 2	No 3 P	robably 4	✓ Unknown
COF	Completed							24a. Was autop		24b. Were	autopsy fir	ndings available
tal Rection: The	5								rmed?	death?	?	on of cause of
ital ician: s certi	Be	25. Was case referred to medical examiner?	sital.			26 Place of De	ath (Check		2 110	1 🗸	res	2 No
of Ving Physi	러	1 Yes 2 No 27. Manner of Death		₽ ✓ ER/Outpa		DOA Other	4 Nursir	ng Home 5	Residenc	ce 6 Oth	ner:	
ading th.	<u></u>	1 X Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time	e of Injury	28c. Injury at W	Vork?	28d. Describe I				
riSiC r Atte er dea recto	ig ig	2 Accident Investigation	28g Place of Inc.	<u> </u>		1 Yes 2						
Divisipital or At cours after dinect filled in by	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - (Specify)	At nome, farm,	street, facto	ory, office building	, etc.	28f. Location (S or Town, S	treet and	Number or F	Rural Route	Number, City
0 ~ = 5	11.2	20a Cartifies		wlodgo doeth -					,			
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: , completely filled in by the fi	욹	- (2.)	To the best of my known the basis of examinated	on and/or inves	stigation, in	tne time, date and my opinion, death	l place, and occurred a	due to the cause it the time, date a	e(s) and r	nanner as sta	ated.	•1
	₹ 2	96. Signature and title of certifier				29c. License numb				te signed (M		
		highir, u	>			O.C.M.E.				mber 8, 20		विवा)
	3	0. Name and address of person who com	pleted cause of death (I	tem 23a)			-					
	2	Ling Li, MD Assistant Med	cal Examiner 1		treet, Ba	timore, MD 2	1201					
Sta Registra		1. Date filed (Month, Day, Year)	Registrar's Sign	nature	report 10							
		UEU I 1 ZUIU	March 1	1 1800	Mal							

DHMH 17 Rev 1/2001 OCMF 2006

ORIGINAL

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav Bertrand 1:00PM /Medical 2016 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Renaissance Gardens Assisted Living Catonsville Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 M 2 X F Director 215-14-7898 02/16/1922 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified of once. 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 715 Maiden Choice Lane, RGT 201 by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ☑ Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Frederick Rausch E11a Smith 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 840 Derby Farms Drive Mrs. Patricia A. Kriewald Severn, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Mem. Park 12/11/2010 Elkridge, MD 22. Name and Address of Facility 2 2nd Avenue SW Glen Burnie, MD 21. Signature of Funeral Service Licensee MON479 Singleton Funeral & Cremation Services, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 4mphoma /Medical Due to (or seconsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 🥳 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probabiy 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

Ves 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Source (Specify) 1: Vine Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To this 27. Manner of Death 1 ☐ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No after death

Director: 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21228 10

DHMH 17 Rev 1/2001

State Registrar Bowlin

maide

32. Registrar's Signature

711

MD

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** nineko 10 1504 /Medical 4a. Facility Name (If not institution, 4c. County of Death 4b. City, Toy, or Location of Death give street and number) Examiner 71 hesalen If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Secu Number Age (In yrs. last birthday) **Funeral** 1□M 2 Min Days 79 Yrs Japan Director unkr Usual Residence of Decedent with the Maryland 10a, State 10h Counts 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23a or 28a-f show the Medical Examiner must be notified at MD Harford Edgewood 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21040 USA 614 Longwood Court Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Asian 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ages 1 and 2 should be fill of Health and Mental H I: If item 27 Is marked ott unkn. unkn. or other treumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Austria / Son 614 Longwood Court, Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of h 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. 12/16/2010 Woodbine, MD 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 21. Signature of Euneral Service Licensee Dorota Marshall Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Live birth Day Month Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has 2 No 1 ☐ Yes the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Inpatient 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death 28b. Time of Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D00 30. Name and adess of person who completed cause of death (Item 23a) (Type, Print) 510 upper Chergeake Dr

State Registrar 31. Date filed (Month, Day, Year)

1 4 2010

DHMH 17 Rev 1/2001

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician 12/8/2010 Ruby Noreen Beatty 1:55 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ellicott City Rehab. Ellicott City Howard If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/13/1916 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex **Funeral** 1□ M 2 😿 F 217-38-6833 94 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County fshow r 28a-f show notified at 1 ☐ Yes 2 No Director MD Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or ed or items 23a o aminer must be 3310 Benson Avenue 21227 USA Funeral death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 7 is marked other than "natural", or item traumatic event, the Medical Examiner I Black, White, etc. 2 should be filed within 72 hours after nand Mental Hygiene. is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. White 3 ☐ Widowed 4 X Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 0 <u>Homemaker</u> <u>Own Home</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franklin W. Wallis Noreen E. Burke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other training once. Dennis W. Beatty, Sr. / Son 87 Lenwood Park, Shippensburg, PA 17257 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 12/16/2010 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signatu of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Pero lie Cardio vasaila Di Jesse /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? ate has been signed | page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes or Attending Physician: rector, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 | Yes 2 | **1** | Yes | 2 | **1** | Yes | 2 | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** | **1** <u>0</u> 4 ☐ Horsing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death.

I Director: A

ed in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only 29b, Signature and title of certifier December 10 2010 Back River Mcck Road Balhmore Maylor 2/22/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 01-109

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10 to 19b Per FH G910 12/28/10 Jh State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Da **Physician** 6:00 Pи December 10 2010 John P. Bolton, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore County 1310 Maple Avenue Essex 8. Date of Birth (Month, Day, Year) 10/23/1941 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 3 M 2 □ F 214-38-8404 69 Maryland Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 United States 1310 Maple Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify: 2 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Machinist/Manufacturing Machinist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Denson ပ John Bolton, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Essex, Maryland 21224 1310 Maple Avenue, Delsa F. Burke (Companion) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 12/14/2010 Brooklyn Park, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 15 month tdenocarcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Physician/Medical attending physic I for use as the b 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy pertormed2 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident the Funeral Directory filled in by th 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, To the Fun completely within 2 To the I

29b. Signature and title of certifier

29c. License number D0059385 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph M. Fuscallo MD

9105 Franklin Square Din Sit 309 Balthwee MD 21237

31. Date filed (Month, Day, Year)

14



State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:50 PM Mary Stephanie Bower December ĭö. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring or 1 Year | If Under 24 Hrs. Montgomery 8. Date of Birth (Month, Day, September 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Hours 1 □ M 2 🛛 F Country)
Idaho Director 337-30-3817 74 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20901 9039 Sligo Creek Parkway #201 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Lobbyist/Activist Unions Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) ည Ernest R. Blondis Mary Claire Steffan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1614 Park Avenue, Baltimore, Maryland 21217 Paul Caiola/Son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Montgomery Crematorium, Inc. 1 Burial 2 X Cremation 3 Removal from State December 17 4 Donation 5 Other (Specify) 2010 Bethesda, Maryland Robert A. Pumphrey Funeral Home, Chevy Chas 7557 Wisconsin Avenue, Bethesda, Maryland 21. Signature of faneral Service Lic Harm mai 7557 Wisconsin Avenue, M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ Small Cell Lung Cancer Medical resulting in death) Examiner Brain Metastases Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to or as a consequence of Obstructive Pneumonia Weeks Due to (or as a consequence of) resulting in death) Last physician a the burial-t Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Dav Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Chronic Obstructive Pulmonary Disease 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ha performed? Yes 2 1 🗌 Yes 2 🖾 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ♣No ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation within 24 hours after death

To the Funeral Director; of completed filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Barbara Duparich, Rsm D 006548 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 M.D. 1500 Forest Glen Road, Silver Spring, Maryland 20910 Barbara Supanich, 32. Registrare Signature 31. Date filed (Month, Day, Year) State 1 4 2010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Lillie **Blyther** November 15,2010 13:37 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Fort Washington Hospital Ft Washington Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Funeral Months Days Hours Min. 1 ☑ M 2 ☐ F 85 17 January Director Guilford Ct., NC 579-30-5117 Usual Residence of Decedent death with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f shore event, the Medical Examiner must be notified at Director MXYes 2 □ No Maryland Prince George's Ft Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2214 Jerome Drive 20744 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural" or iten any injury or other traumatic event, the Medical Examina Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black þ Specify: 3℃Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Twelve Two Counselor DC Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abram Spencer Johnsie Leake ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Savetre Blyther/Daughter 2214 Jerome Drive, Ft Washington MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 🗷 Removal from State 30 November Quantico National Triangle, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 20020 21. Signature of Funeral Service Ligens eDonald R. 22. Name and Address of FacilityRobert G Mason Funeral Home Inc Gray 1661 Good Hope Rd SE, Washington DC 20020 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat ause (Final Atheroscleratic **Physician** Coronar disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) Due to (or as a consequence of) law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) ed by the detached f 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? g 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Diab 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy lipidemia performed? Yes 2 No certificate 1 ☐Yes 2 🗷 No 1 ☐ Yes 25. Was case examiner? director, erred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2. XONo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this After this funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 5 Pending death. 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a, Certifier (Check only one)

P.O. Box 68760, Division of Vital Records, Hospital or Attending Physician: ithin 24 hours after death.

the Funeral Director: A simpletely filled in by the fu completely 0

MD	D46741	November 15, 2012
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deepak Sachdeva, MD		
31. Date filed (Month, Day, Year) DEC 14 2010 Sexual 8. Square		

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifler

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Claire Blackmer Whitney 4:51 Рм 1 กั 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Harford Churchville 205 White Thorn Way If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday **Funeral** Country) 5/2371926 84 Director 034-14-4733 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State "natural", or items 23a or 28a-f sho Director 1 🗆 Yes 2 🄀 No Churchville Maryland Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21028 Funeral 205 White Thorn Way 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2X No Specify White ģ 1 Never Married 2 Married ☐ Yes Maryland 21215-0036 1 ☐ Yes 2 Ϊ No Specify: If Yes. Give Completed 3 X Widowed 4 ☐ Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Education School Teacher should be filed with and Mental Hygien 7 is marked other th 12 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louise Bishop 2 Whitney Parker permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 506 Harrisville Rd, Colora, MD 21917 Keith Blackmer / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harford Mem. Gdns. 12/15/2010 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Aberdeen 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.
333 S. Parke St, Aberdeen, MD P.A. 1D 21001 Parké 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final AFTERIOSCLEROTIC CARDIOVASCULAR DISEASE Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) signed by the a a I Inknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2: autopsy performed? Yes 2 X No death? 1 Yes 2 No Hospital or Attending Physician: 24 hours after death.

Funeral Director, After this certifica To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Hospital: Other: 4 \square Nursing Home 5 XResidence 6 \square Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 28c. Injury at Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred work? 1 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

ORTH AVE

REL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AB

1 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 December 2:50 P M В. Cantor Arnold Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 215 Cinnamon Lane <u>Edgewater</u> 8. Date of Birth (Month, Day, June 12, 9. Birthplace (State or Foreign Country) New York If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) **Funeral** 1**X** M 2 □ F 211-24-3801 June Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at Director MD Anne Arundel Edgewater 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 215 Cinnamon Lane 21037 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc Armed Force þ 1 Never Married 2 X Married 2 X No Yes Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify. Specify: White If Yes, Give "natural", 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) (Specify only highest grade completed) during most of working mit. Page 1 and 2 should be filed within 73 partment of Health and Merital Hygiene. outant. If item 27 is marked other than 'injury or other traumatic event, the Me. College (1-4 or 5+) Elementary/Seconday (0-12) AFLCIO - Labor Org. Economist Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Cantor Edward Florence Cohen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 215 Cinnamon Lane Barbara Cantor, wife Edgewater Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 12/13/10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb once 299 Frederick Road Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAILURE CONGESTIVE HEART Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ARTER vears CORONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) nding physician ause as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be each hours after death.
 Funeral Director: After this certificate has been signed by the attending physicia P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No jo Month Day Veal Pregnant at time of death 5 Other (specify) signed by the a a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? \$ GASTYO INTESTINAL 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Division of Vital Records, 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an ANEMIA autopsy performed? 1 Yes 2 No 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 Hospital 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the I within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie December 13, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland 21146 J. Katz, M.D 31 Robinson Road Severna Park Stephen

DHMH 17 Rev 7/2009

State Registrar Registrar's Signatur

10-09579 Curtis Daniel Cary

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day December 13, 2010 Medical Examiner Curtis Daniel Cary 0630 hrs 4a, Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 119 Sipple Avenue Baltimore **Baltimore County** 5. Social Security Number If Under 1 Year If Under 24Hrs. **Funeral** 7. Age (In yrs. last birthday) Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Paltimore, Months Days Hours 220-80-3495 Director 45 March 29,1965 1 X M 2 F Maryland Yrs Usual Residence of Decedent 10, 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Baltimore show 1 Yes 2 X No items 23a or 28a-f shoust be notified at once. Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-7 sho
injury or other traumatic event, the Medical Examiner must be notified at once Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 119 Sipple Avenue 21236 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married 1X Yes White 3 Widowed Yes, Give Year 4 Divorced 1 Yes 2 X No specify: Specify: \$ 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self-Employed 12 3 Artist 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Curtis Cary Joyce L. Ribetsky Be 19a. Informant's Name/Relationship (Type, Print) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Cary/Wife 119 Sipple Avenue, Baltimore, MD 21236 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State Evans Funeral Chapel - Bel A December 1 Burial 2 X Cremation 3 Removal from State 17, 2010 Forest Hill, MD Donation 5 Other Specify: ²² Name and Address of Facility Evans Funeral Chapel & Cremation Service 8800 Harford Rd. Parkville, MD 21234 Signature of Funeral Service License Physician 2/3d. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Retween Onset and failure. List only one cause on each line Medical Death Oxycodine Intoxication And Alcohol Use **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause. (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medica e attending physician a for use as the burial X UNPENDED AMENDED #23a,27,28a-f,perME,G911,1/28/11,WS The law requires that the death certificate be Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth 2 Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown signed by the 1 be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was ar 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has death? performed' ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Hospital 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: Scene 1 Yes No After 1 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural J Director: 1 Yes 2 X No within 24 hours after death.

To the Funeral Director: 5 Pending 12/13/2016nd6:25am Accident Unknown Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be Suicide or Town, State) 119 Sipple Homicide Baltimore 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Ca 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) OCME O.C.M.E. December 13, 2010 Name and address of person who completed cause of death (Item 23a) 1-pend Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible: State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 ΦNNA COOKE 4.45 RM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore City 3006 Oak Crest Avenue Baltimore 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 - M 2XXF Months Days Hours Min. (Month Country)
Maryland 92 Director 215-05-6887 Dec Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d Inside City Limits Director r 28a-f sl notified Maryland Baltimore City 1XXYes 2 ☐ No Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a o Funeral 3006 Oak Crest Avenue 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※※ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 ☐ Divorced Completed er than "natur , the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 yrs. College (1-4 or 5+) Beautician Beauty Shop is marked other aumatic event, th permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, ti once. Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Charles Henry Fritsch Myrtle Martha Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3006 Oak Crest Avenue Baltimore, Md. 21234-Elbert R. Cooke, Jr. (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Moreland Memorial Pk. 12-13-2010 Baltimore, Maryland 22. Name and Address of Facility re of Funeral Service Dicenses Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MU LTI-INFARCT DEMENTIA Physician/ Medical resulting in death) Due to (or as a consequence of): years Examiner YPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or aş a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Hospital or Attending Physician: The law requires that the death certificate be exe Physician/Medical DISEASE ARTERY Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year signed by the a 1 ☐ Yes 27 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 performed After this certificate 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **⊈** No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation 24 hours after death Funeral Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, do ath occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my browledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D0015462 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIJUEL KARACUSCHAWSKY H.D. 20 200 E. 33 Nd ST #640 BALTO, MD 21218 VC KARACUSCHANSKY 31. Date filed (Month, Day, Year) 32. Registrar's Signatur

DHMH 17 Rev 7/2009

Registrar

4

L

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dec 8, 2010 **Physician** Janie Clarke 6:20 A M /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner **Eden Wald Nursing Home** Towson **Baltimore** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2×1F Months Days Hours Min. 220-05-3162 95 MD Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. Count MD **Baltimore** Towson 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Southerly Rd. 21204 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 1□ Yes 20 No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiens. Important: If item 27 is marked other than "nt any injury or other treumatic event, the Madis once. Elementary/Secondary (0-12) College (1-4or 5+) office manager insurance company unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Clarke Janie Rootsie Clark ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William McQuire nephew 7805 Mandan Rd. Greenbelt, MD 20770 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Popation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Atlantic Crematory, LLC Dec 10, 2010 Glen Burnie, MD Signature of Funeral Service Licenses 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End stage /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ Vo
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 20 No 1 | Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funerel Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medicai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Susanschen CRNP R154032 Dec. 8,2010 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 800 Southerly Rd Towson, MD 21286 32. Registrar's Signature and Registrar

10-09451

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

David Carter		State or State	of Maryland / Depa <i>Cer</i>	rtment of tificate of		Mental Hy		g. No. 2011	1 19292
Physiciar Medical Examin	1. Q	pecedent's Name (First, Middle,La	1 7			2	Date of Death Month December	n Day Year	3. Time of Death 2043 hrs
		Facility Name (if not institution, gi University Hospital	ve street and number)	4	b. City, Town, or Loc Baltimore	cation of Death		4c. County of Dea	th
Funeral Director	2		ex 7. Age (In yrs. la	est birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birt	h(MM/DD/YYYY) 9. B Fore	irthplace (State or ign///www.ga/country)
WD 21215-0036 nd 2 should be filed within 72 hours after death with alth and Mental Hygiene. m 27 is marked other than "natural", or items 23 raumatic event, the Medical Examiner must be no	10a	Decedent's Education (Specify of lementary/Secondary (0-12) Father's Name (First, Middle, Last	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: nly highest grade completed) College (1-4 or 5+) Type, Print) Afar Guardian	16a. Decedent during mo	10f. Zip Code 2/2 Decedent of Hisparis, specify Cuban, Mary Signature of Working life. DC 3 e Kell J. 18.M.	ic Origin? (Specexican, Puerto Revican, Puerto Revecify: (Give kind of woo) NOT use retired Mother's Name (For Number or Ruit	cify Yes or No- ican, etc.) rk done d) First, Middle, M	White, etc. Specify: Blooming 16b. Kind of Business Aiden Surname) YY S Der, City or Town, State GATO . M. G	A- prican Indian, Black, Ack Wilndustry
Baltimor	1 21 23a. Immor or ox	Burial 2 Cremation 3 Donation 5 Other Specify Signature of Fundal Service Licer Author Part I. Enter the disease, or comp failure. List only one cause on ea	Removal from State	rematory or other in MOM 23. Na 23. Na 24. Na 25. Na 27. On not enter the	ar place) If the metal are and Address of the Miller All Miller	12-1 Lighty las	7-2010 5 Fans a/to.	Ballo.	Approximate Interval Between Onset and Death
), Box 68760, the death certificate be executed by the attending physician and ached for use as the bunal - transit Physician/Medical Examiner	IF FE 23b. \\	d. UNPENDED EMALE: Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown	9 Olikilowii	ancy 2 Feta th 5 Othe	er (Specify)	ectopic pregnanc	y	23d. Date of deliver Month	У Day Year
Records, P.C The law requires that cate has been signed page 2 should be dete		II. Other significant conditions	contributing to death but not res	sulting in the un	derlying cause given	in Part I.		24b. Were at prior to death?	bably 4 Unknown utopsy findings available completion of cause of
Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been signified in by the funeral director, page 2 should be delical Certification: To Be Completed	27. M 1 2 3 4 29a	Anner of Death Natural 5 Pending Accident Investigati Suicide 6 Could not determined Certifier 1 Certifying Physici	28a. Date of Injury Dec 8, 2010 28e. Place of Injury - At honobe	e, death occurre	3 DOA Other ury 28c. Injury at 1 Yes factory, office building	Work? 28 2 V No 28 ng, etc. 28 nd place, and du	Home 5 R Rd. Describe houbject shot St. Location (Stror Town, State 17 Westwood e to the cause)	reet and Number or Rute) d Avenue, Baltimore (s) and manner as stat	ural Route Number, City e, MD ed.
To with Young	30. N	Signature and title of certifier	and manner stated.	23a)	29c. License nui O.C.M.E	mber		29d. Date signed <i>(Mo</i>	nth, Day, Year)
State Registra	~	ate filed (Month, Day, Year) DEC 1 4 201	32 Registrar's Signature	bark					
DHMH 17 Rev 1/2001			/	ORIGINAL				OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Licember Physician/ COOKE LOTTIE MAE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Deat **Examiner** N/A 8. Date of Birth (Month, Day, OCT 28 If Under Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Hours 1 ☐ M 2 🗶 F WEST VIRGINIA 79 Director 232-46-6260 Usual Residence of Decedent 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 - No MARYLAND N/A BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number by Funeral 21217 U.S.A. APT 506 342 BLOOM ST. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc XX Never Married 2 Married 1 Yes If Yes, Give 1 Tes 2 No Specify Specify: Completed 3 Widowed 4 Divorced BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ROSEWOOD STATE HOSP. NURSING ASSISTANT 12th grade Be Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ CHANNIE THOMPSON RICHARD COOKE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 342 Bloom St., Apt 506, Baltimore, Md., 21217 Walter Cooke/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 Cremation 3 Removal from State 12-15-10 LOUDON PARK CEMETERY BALTIMORE, MARYLAND 21. Signatur ung al Name and Address of Facility LLIAM C BROWN COMMUNIT 206 W NORTH AVENUE, BAL . Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi that initiated events resulting in death) Last o (or as a consequence of) nding physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 Yes 2 No Month Day Year Pregnant at time of death 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed?/ Yes 2 1 No 1 Yes 2 No 26. Place of Death (Check only one) **Division of Vital** Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death To the Funeral Director. completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

State Registrar

Medical

29a, Certifier

(Check

29b. Signature and title

DHMH 17 Rev 7/2009

Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month (2 2010 Physician/ 2114 PM James Conrad Clarke Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan 28, Square Hospital Baltimore FRANKLIN Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 62 1948 Director 217-50-4076 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Director or 28a-f s notified 1 Yes 2 No MD Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ò must be i Funeral 21237 United States 1315 Chesaco Ave Apt. r items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?
1 ☐ Yes 2. No Black, White, etc. 6 þ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: "natural" Completed 3 Widowed 4 Divorced White Year or Dates is marked other than "naturaumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Insurance 12 Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lillian A. Fischer Louis C. Clarke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Lorie Myers /Daughter 2507 Parliament Dr. Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1. Department of Important: If it 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State Dec 1 5 Beltsville, Maryland 4 Donation 5 Other (Specify) 2010 Chesapeake Crematory 21. Signature of Funeral Service Licenses 22. Naccentades of Family Funeral Alternatives MO1585 Kebecco 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician Encephalo Hepatic disease or condition resulting in death) Medical Due o (or as a consequence of): Examiner 1V C6 Sequentially list conditions, Examine any, leading to immediate cause. Enter Underlying ARTER disease Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or linjury oronary that initiated events resulting in death) Last Due to (or as a conseduence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death signed by the a d be detached for 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed plnous 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy page 2 performed death? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation after deatl Director. within 24 hours after de To the Funeral Directo completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29b. Signature and title of certifier 12/09/2010 RESOUDO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN SQUARE DR Balto md 21237 Voore Navcen

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

4

DEC

ರ

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ MO ar ne 20 H Medical 4a. Facility Name (if not institution, give street and number)
Season's Hospice . City, Town, or Location of Death Randallstown County of Death
Baltimore **Examiner** Hospice 5. Social Security Number 575-72-2019 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 🗆 M 2 🔀 F 55 Director 0/22/1955 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Savage MD Howard 1 XYes 2 No 10f. Zip Code 10g. Citizen of What Country? 8434 Commercial Street 20763-9639 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 X Yes 2 \(\text{NAir} \) Black, White, etc. 1 X J Yes 2 Air Force If Yes, Give Marine Rers. Year or Dates. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Polynesian Completed 3 - Widowed 4 - Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government 12 Supervisor Be 17. Father's Name (First, Middle, Last)
Paul Ching, 18. Mother's Name (First, Middle, Blanche Mahoney 2 19a. Informant's Name/Relationship (Type, Print)
Paul Ching, Jr. Address (Street and Number or Rural Route Number, City or Town, State, Zin Code)
Dexter Chelsea, Dexter, MI 48130 Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 12/14/2010 Woodbine, MD Final Journey Crem. 4 Donation 5 Other (Specify) Dofota Marshall 22. Name and Address of Facility Maryland cremation Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Pnysician Throm Que disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown been signed by the s Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has I autopsy perform 1 Yes 2/N 2 🗌 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) a Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes မြ 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation is my entired. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

8+1 State

Registrar

only one

29b. Signature and title of

30. Name and address of person who comp

31. Date filed (*Month, Day, Year*) **DEC 1 4 2010**

32. Registrar's Signature

3 Certifying Nurse Practionar: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

		State of Marylan		rtificate of E			jierie eg. No.0 0 1 0	nonno
	8	Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Dea	th	3. Time of Death
Physic		Margaret T. Clark				Month	Day Year 5, 2010	7:50 P M
/Med Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	Decembe	4c. County of Dea	
Ž. Z.		Wilson Health Care Center		Gaithers			Montgom	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. Bi	rthplace (State or Foreign country)
Director		217-32-0926 1□M 2⊠F 97	Yrs.			December	10,1912	olorado
pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City	y, Town or Lo	ocation	-			10d. Inside City Limits
aryla shov	7	Tod. Otalo						1 □ Yes 21 No
he M 28a-f otifie	Director	Maryland Montgomery S 10e. Street and Number	Silver	Spring 10f. Zip Code			10g, Citizen of What C	country?
with t	à			·		1	ŭ .	
sath s 23	eral	14808 Lindsey Lane 11 Marital Status 12. Was Decedent Ever in U.	.S. 13.	20906 Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-	United Sta	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	Armed Forces? 1 ☐ Never Married 2 ☐ Married I ☐ Yes 2 ☑ No If Yes, Give		If Yes, specify Cubar 1 ☐ Yes 2 ☑ No		Rićan, etc.)	Black, Wh	ite, etc. White
inal ylails LETS 10000	Completed by	3 ☑ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education	16a. Dece	dent's Usual Occupa	ation	I	16b. Kind of Busines	
hin 72 e. In "na"	plete	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done d DO NOT use retired,	uring most of work)	ing		
d with	l o	4	Hon	nemaker			Own Hom	e
al Hy lothe	Be (17. Father's Name (First, Middle, Last)					Maiden Surname)	
Ment Ment arkec	P	Charles H. Treusch				Huber		
2 shg and is m		19a. Informant's Name/Relationship (Type. Print)	1				er, City or Town, State, ng, Maryla	
and lealth m 27		Edna J. Clark / Daughter	!		1	Date	20c. Location - City of	
Dermit. Pages 1 a Department of Her important: If item any Injury or other once.		1 M Burial 2 Ucremation 3 Unemoval from State		osition (Name of ematory or other place Cemetery	1	ber 10,	Chevenne,	
nit. P artme ortan Injur		21. Signature of Maneral Servige Linguistic					ome Rockvil	
permit Depart Import any Irr		Let I tell MO1607						arvland 20850
		23a. Part1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line.	th. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
Physician			- 6	estte	il color			Onset and Death
/Medica	_	disease or condition resulting in death) a. Due to () as a consecutive a	quence of):	eartfo				The same
Examine	1							
	ner	Sequentially list conditions, if any harding to immediate cause. Enter Underlying Cause (Disease or injury	quence of):					
nd ransi	Examiner	that initiated events c.						
icate be executed physician and sthe burial-transit	Ĕ	resulting in death) Last Due to (or as a consec	quence ot):					
icate be exec	edical	d				 .		
	Mec	IF FEMALE: 23c. If yes, outcome pf pregn	ancy				22d Date of s	lolivon.
death certifice attending pod for use as	ian/	in the past 12 months?	al death 3	□Ectopic pregnancy			23d. Date of o	Day Year
	Physician/Me	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of 6 9 ☐ Unknown	ueam 5					
ਰਿਕ ਜ਼ਿੰ		Part II. Other significant conditions contributing to death but not res	sulting in the u	underlying cause give	en in Part I.	23e. Did t	obacco use contribute	to the cause of death?
uires t signe d be o	l by	Chronic obstructive on				1□	Yes 2127No 3□	Probably 4 ☐Unknow
w requir	ete	Rheumataid arthret		De Sha	601	24a. Was	an 24b. Were	autopsy findings availabl
The law requir ate has been si page 2 should I	Completed	Weight lass ducks in		tocal	si o int	auto _l perfo	rmed2/ death	o completion of cause of
	င္ပ	25. Was case referred to medical	anis	and are	26. Place of Dea			es 2□No
	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	TER/Outpatie	ent 3 T DOA Oth			dence 6 □Other (S	necify)
	ПΕ	27. Manper of Death 28a. Date of Injury	28b. Time				how injury occurred	
Attending F r death. ector: After by the funer	ţ	1 ☑ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury		Yes 2 ☐ No			
	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At rebuilding, etc. (Special Could not be building, etc. (Special Could not be building, etc. (Special Could not be building).	nome, farm, s	treet, factory, office		28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,
ospital or A hours after uneral Dire			and all a	alle annumeral -tale : **	ma data and al	and due to the	aguacía) and mar	as stated
4410	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my km (Check only one) 2 ☐ Medical Examiner: On the basis of examin and manner stated.	iowledge, dea nation and/or i	ith occurred at the til investigation, in my o	me, date and place ppinion, death occu	e, and due to the irred at the time,	date and place, and d	due to the cause(s)
To the I within 2 To the I complet	Mec	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signed (Mo	
⊢≯⊢ŏ		> HoRaker (Firs off	1. 1/1	en 04	45		December	26,2010
		30. Name and address of person who completed cause of death (Ite		e, Print)				
7		14 ROBERT DIRSCHBALLY		64	THERS	BURG	LENNE 20	1877
9	State	31 Date filed (Month Day Year) 32. Registrar's Sign						
Regis		DEC 14 2010 But S.	Bar	Car				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0 Medical Pacility Name (if not institution, give street and number Examiner Town, or Location of Death County of Death Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Min MD Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits Randallstown Baltimore 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Allenswood U.S.A 9002 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Maryland College (1-4 or 5+) Elementary/Seconday (0-12) Budget Government 12th grade trialust Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) un L ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelia D. Drake Allensinood load Pay dall stown 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place laltimore, MD 18 Erreannount (rematery 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Everne Faneral Senico oadPandallstown UD 21133 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause Eigh Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year Unknown 1 L Yes 2 l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed' 2 🔍 No 1 Yes 25. Was case referred to medical examiner? Be Liter 26. Place of Death (Check only one) Hospital: 2 No Other: NOORE ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1X Natural 5 Pending iniury Accident 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the only one 29b. Signature and title 29d. Date signed (Month) 30. Name and address of (Item 23a) (Type, Print) of death 0 32. Reg State strar's Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ DAVID MORRIS D1665 08:30AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSP. MONTGOMERY GAITHERSBURG Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, MAY 17, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 1 💆 M 2 🗆 F 63 228-62-9463 **Director** Usual Residence of Decedent show or 28a-f shov notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director MONTGOMERS MD. GAITHERSBURG 1 ✓ Yes 2 ☐ No 10e, Street and Numbe 10g. Citizen of What Country? ö must be r by Funeral STRATH-HAVEN DR. 20586 20886 USA Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK 3 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) SAFEWAY FOOD Elementary/Seconday (0-12) College (1-4 or 5+) CLERK STORE 12 TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 01665 JULIAN GASKINS MABEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20586 STRATH-HAVEN DR. GAITHERS BURG, MO 20886 (WIFt) ESTHER A. DIGGS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State RESTHAUEN MEM. GAR. DEC. 10,2010 FREDERICIE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GARY L. ROLLINS FUNERAL HOME 21. Signature of Funeral Service Lipenses Bany X 110 WEST SOUTH ST FREDERICK MD. 21701 23a. Part 1. En ... he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final carcinoma pancreas cell Physician/ Small disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner brain mets lumbar Sequentially list our difficult, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury 10095 signed by the attending physician and doe detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 687 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 2 No the Hospital or Attending Physician: The Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖪 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manper of Death 28d. Describe how injury occurred Certificate: 🗹 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number December 2010 41162 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20874 Germantoun MD Doctor's Drive ganti 19529

State Registrar 31. Date filed (Month, Day, Year)

1 4 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 90299 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 7:11 December A. M Barbara Smith Dannettel Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Timonium <u>Baltimore</u> Stella Maris Hospice Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland Months Days Hours Min (Month, Day, Year) 1 □ M 2 😾 F 215-42-0036 69 Sept. Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10d. Inside City Limits 10c, City, Town or Location with the Maryland Director 1 ☐ Yes 2 😾 No Maryland **Baltimore** Sparks 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21152 14 Rainflower Path #303 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No 1 Never Married 2 Married þ 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Communications remit. Page 1 and 2 should be filed wit epartment of Health and Mental Hygier important: If item 27 is marked other to my injury or other traumatic event, the vince. Public Relations years Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Henry Smith Marcia Onion 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21152 Benjamin B. Berquist (son) 100 Far Corners Loop Sparks. Marvland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Green Mount Crematory 4 ☐ Donation 5 ☐ Other (Specify) 12-14-10 Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home 6500 York Road Baltimore, Mary 21. Signature of Funeral Service Licenses Fer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OBSTRUCTIVE PULMONARY Pnysician/ HEONIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequestially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown been signed by the atte should be detached for Month Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No the Hospital or Attending Physician: The law requires 1 Yes 3 ☐ Probably 4 ☐ Unknown Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has I autopsy this certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Hospital 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA Division of funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural work?
1 Yes 2 No iniury 5 Pending thin 24 hours after death.

the Funeral Director: After mpleted filled in by the fun 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the within To the comple 29b. Signature and 29d. Date signed (Month, Day, Year) 2010 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) 2300 DULLNEY VALLEY RD TIMUNIUM

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

DEC 1 4 2010

1:11an

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year MANUEL DREIZEN December 10:45 AM Medical 2016 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HUSPI +,1 of Raltimere N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1**XX**M 2 □ F Months Days Hours Min. 0771871924 86 Director 100-16-3263 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD **BALTIMORE** BALTIMORE 1 🗆 Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6603 WICKFIELD ROAD 21209 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces

1 Y Yes 2 [
If Yes, Give
Year or Dates. Black, White, etc Completed by 1 Never Married 2 X Married 2 No Maryland 21215-0036 1 ☐ Yes 2XX No Specify: WHITE Specify 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)
5 + Elementary/Seconday (0-12) **ENGINEER** WESTERN ELECTRIC other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot မ SCHNEIDER CHARLES DREIZEN ROSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARILYN DREIZEN/WIFE 6603 WICKFIELD ROAD, BALTIMORE, MD 21209 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🎇 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Department o Important: If any injury or ō BETH EL MEMORIAL PK. 12/13/2010 RANDALLSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, skock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ **Medical** resulting in death) Due o (or as a consequence of): **Examiner** Sequentially list conditions Physician/Medical Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying the attending physician and hed for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed thin 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ate has been signed by the atter page 2 should be detached for u in the past 12 months? Day 5 Other (specify) Year Pregnant at time of death 2 No g | Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? fibrillati 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed Yes 2 2 1 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) December 12, 2010 188191579

State Registrar

VQ

30. Name and address of person

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.P

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12/11/2010 Physician/ 8:00 P M Charles Wesley East Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 K M 2 D F Hours 1⁽²7⁽²7⁽²7)⁽²7)⁽²7)⁽³35 Yrs Director 215-32-5045 74 Usual Residence of Decedent or 28a-f shov 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits **Funeral Director** the Medical Examiner must be notified 1 Yes 2 No MD Carroll Westminster 10e. Street and Numbe 10g. Citizen of What Country? 23a 1001 Cindy Lane 21157 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Building Systems Manager Ryland Group other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ၉ Page 1 and 2 should be Clarence East Helen Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trace once. Melynda East/Wife 1001 Cindy Lane, Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Carroll Crematory 12/16/2010 Winfield, MD Signature of Funeral Service Licensee 22 Name and Address of Facility Funeral Home & Crematory, P.A. Old Liberty Rd., Winfield, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably Value Unknown 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death? 2 🗆 No Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospita Other: INPATIEN 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Director 6 Could not be 3 🗆 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

10

Registrar

DHMH 17 Rev 7/2009

State

and title of certifier

NO

address of person who completed cause of death (Item 23a) (Type, Print)

tes was

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edwards Glenn Robert Jr. December 2010 1:45 P M Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day Ye Months Days Hours 68 **Director** Oct. 1942 Maryland 215-40-1878 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Bethesda 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 7511 Oldchester Rd. 20817-6162 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 X Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give White Specify. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Chauffeur Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Glenn Robert Edwards, Sr. Ver1 Joines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Lipin / Sister 7511 Oldchester Rd., Bethesda, MD 20817-6162 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State Chesapeake Crematory | 12/13/2010 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Doenses M00382 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 1 Sleet Xolunan 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ Metastatic Lung Cancer disease or condition resulting in death) months Medical Due to (or as a consequence of): Examiner weeks Pneumonia - Obstructive Sequentially list conditions Examine If any, leading to immedicause. Enter Underlying Due to (or as a consequence of): Pleural Effusions Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and weeks signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant 9 ☐ Unknown Yes 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ AIDS, COPD, Atrial Fibrillation 1 Nes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 performed? 1 Yes 2 No 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) 2 No Other: မ 1 🗌 Yes 1 Sinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending work? Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined

Division of Vital Records, P.O. Box 68760 filled in by 24 hours a completed To the l within 2 To the l

> State Registrar

Medical

29a. Certifier

(Check

only one)

3

Barbara Supanich, RSM, M.D. 1500 Forest Glen Rd., Silver Spring, MD Year) 4 2010 egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suparich RSM, NO

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

006548

29d. Date signed (Month, Day, Year)

20910

29c. License numbe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Arthur J. Fitzgerald 2010 11:45 AM Dec. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rock Spring Village Forest Hill Harford County 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Months Days Hours May 1933 77 408-48-2477 Yrs. Director Tennessee Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location at 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a Harford County White Hall Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21161 Funeral 4758 Carea Road United States within 72 hours after death 11, Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) an "natural", or iter Medical Examiner 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Aberdeen Proving (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the General Engineer Grounds Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clyde Valentine Fitzgerald Vera Pedigo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 308 B Willrich Circle, Forest Hill, Maryland 21050 Linda Fitzgerald (Spouse) 20a. Method of Disposition
1 ☐ Burial 2 🏿 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel 12/10/2010 20c. Location - City or Town, State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vans Funeral Chapel & Cremation Services-Bel Air B Newport Drive, Forest Hill, Maryland 21050 fer team of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ ESOPHAGRAL disease or condition resulting in death) MONTH Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 the attending yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death after death. Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier 1. Secritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dead occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title of certifier 00058475 DECTABIL 10 2010 PHYSTUTAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHZUIP BONIN BIZCAT 31. Date filed (Month, Day, Year) 32. Registrar's Stgnature State

DHMH 17 Rev 7/2009

Registrar

NEC

Registrar DHMH 17 Rev 7/2009

State

Calhes

32. Register's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decede s Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Baltimore Seasons Hospice Randallstown 5. Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pa. 8. Date of Birth **Funeral** 1 XM 2 🗆 F Days 533-80-3161 **Director** Usual Residence of Decedent 10b. County 28a-f shov 10a. State than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Funeral Director 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Catonsville 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 642 Orpington Rd. 21229 USA permit. Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. 5+College (1-4 or 5+) Elementary/Seconday (0-12) Administrator Bus Transportation Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Herbert Flister MaryAnn Hrapchak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 Arrowhead Ridge Hedgesville, West Va. 25427. Herbert Flister(Father) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State All County Cremation 12/14/2010 4 ☐ Donation 5 ☐ Other (Specify) Sykesville,Md. 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury) Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? 1 🗌 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital မ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 😿 01 n 24 hours after deam.

he Funeral Director: After the 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 No Investigation 3 Suicide 4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title

State

Registrar

30. Name and address of pe

31. Date filed (Month, Day, Year)

son who completed cause of death (Item 23a) (Type

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Pleas	se Type or P								egible		
	1	For State Registrar		State of I	viaryian		rtment of l		id ivier		Reg. No.	010	39	306
Physiciar		1. Decedent's Name					-			Date of Dea Month	th Day 4	Year	3. Time o	
Medica	al .	David		e Gividen ive street and number	r)		4b. City, Town, o	or Location of F		ec.		2010 unty of Deat		8 A M
Examine	er			gton Medi		nter		en Buri					runde1	
Funeral		Social Security Nur	mber 6		Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8.	Date of Birtl	(Vear)	9. Bir	thplace (State	or Foreign
Director	ŀ	217-60-49 Usual Residence of D		XWZGI	56	Yrs.			Ju	Month, Day 11y 23	195	4	Kent	ucky
show	ē		10b. County		10c. City	y, Town or Loc							10d. Inside C	City Limits
28a-f	Director	MD		Arundel				Burnie						s 2 X No
permit, rage 1 and 2 should be lined within 7.2 hours aren death with the manyanu bearment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Merkeal Examiner must be notified at once.	ra D	10e. Street and Numl				10f. Zip Code		-	of What Co d Stat					
tems ?	Funeral	11. Marital Status	eet bw	12. Was Decede		3. 13. W	/as Decedent of I	21061 Hispanic Origin	? (Specify	Yes or No-		Race - Ame	erican Indian,	
or i	হ	1 Never Marrie		Armed Force 1 Yes 2 If Yes, Give	No No		Yes, specify Cub ☐ Yes 2 🛣 No		derto nica	an, etc.)	Spe		erican	
atural	eted	3 Widowed 4	15. Decedent	Year or Dates	i.		ent's Usual Occu		-			of Business	dian	
Median "n	Completed	(Spec	cify only highest	grade completed) College (1-4 of	or 5+)	(Give k	ind of work done NOT use retired	during most of	f working	Ī	TOD. TUTO		,	i
ygiene ygiene her th	0	8					Chef	T				Dine	r	
on med antal H ced of cever	일	17. Father's Name (Fi								irst, Middle, i ck1ey	Maiden Suri	name)		
s marl		19a. Informant's Nar				19b. Mailin	g Address (Street	1			; City or Tov	vn, State, Zi	p Code)	
alth a n 27 is ner tra		Edith Bem	ben / D	aughter		303 A	Street	SW, Gle	en Bu	ırnie,	MD 21	.061		
or off		20a. Method of Dispo	Cremation 3	B ☐ Removal from St	ate c		atory or other pla		Date	1		-	Town, State	. ,
artmer artmer ortant injury		4 Donation		ecify) ensee Alyson			natory I Name and Addr						Maryla Maryla	
any per		-Agre	LITE		=		99 Frede							
		23a. Part 1. Enter th shock, or heart	ne disease, or c t failure. List on	omplications that cau ly one cause on each	sed the deat								Approxima Interval Be	etween
hysician/ Medical		Immediate Cause (F disease or condition resulting in death)		a. 1-100	4e P1		2010	Inc	٥٧٥	i city	ر		Onset and	Death
Examiner			2000000	2/PC	as a consequ	-0727	BARO	255 5	SUR	ععي	~			
- +	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury) Due to (or as a consequence of):												
and -trans	Examiner	that initiated events												
5 - 6	_				Due poor as a consequence of): Due poor as a consequence of): The poor as a consequence of):						7			
incate be ex ng physiciar as the buris	Med	IF FEMALE:								_	<u> </u>			
atti cer attendi for use	cian/	23b. Was decedent p in the past 12 m	nonths?	23c. If yes, outco 1 ☐ Live Bir 4 ☐ Pregnai	th 2 🗌 Feta	al death 3 🗔	Ectopic pregnar Other (specify)	псу			230	d. Date of de Month	elivery Day	Year
y the a	Physician/Medical	1 Yes 2 L 9 Unknown	J No	9 🗌 Unknov										
gned b	by	Part II. Other signific	cant condition	s contributing to deat		sulting in the ur	nderlying cause g	iven in Part I.					o the cause of	/
equire been si	eted	1,465	7	120ch		-		_	-	24a. Was a			Probably 4 V	
e law i e has b ge 2 s	Completed	910	lm a	Cat at	00	78	2003	<u></u>		autop perfo	rmed)	prior to death?	completion of	
an; In	Be Co	25. Was case referre examiner?	ed to medical	7000			26. [Place of Death	(Check on		2 No	_ I ⊔ Ye	s 2 No	
nysici his cei	မ	1 ☐ Yes 2 🗷			patient 2		t 3 ∐ DOA			5 Resid			cify)	
ding F	cate:	27. Manner of Death 1 ☐ Natural 2 ☐ Accident	5 Pending Investiga		injury Day, Year)	28b. Time of injury	28c. Inju wo: M 1 [- 1	d. Describe h	ow injury oc	:curred		
Arten er deat ector: by the	Certificate:	3 Suicide 4 Homicide	6 Could no	ot be 28e. Place of	Injury - At ho		et, factory, office		28f	f. Location (S City or Tow		umber or Ru	ural Route Num	nber,
urs after or are are are are are are are are are ar														
To the hospital or Autonomy Prystolan: The taw requires that the deal within 24 hours after death. To the Funeral Director, After this certificate has been signed by the at completed filled in by the funeral director, page 2 should be detached for	Medical	(Check 2	Medical Ex	Physician: To the bes aminer: On the basis Nurse Practioner: To	of examinatio	n and/or invest	igation, in my opin	ion, death occu	urred at the	e time, date a	nd place, an	d due to the	cause(s) and m	ianner stated.
To the	2	29b. Signature and t		/		0	29c. Licen		- ~				th, Day, Year)	
		Me	22	3 Kro	abr	eth	VI	415	27		13	1611	D	5 . A
		30. Name and addre	w goerson w	ho completed cause	of death (Item	(Type, P	ad.	52	te :	300	N.	120	ou Il	e, MV
Stat	e	31. Date filed (Month	h, Day, Year)	32. Reg	istrar's Signa	iture		-01		<u> </u>	1		, — , ,	- "
Registra	ar		GEC 1	4 2010	Cassin	B. H	Barre							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Physician/ 3:00 PM GEARTNER VAUNDA DEC Medical 4c. County of Death
Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Pikesville 602 McHenry Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 □ M 2X□ F June 6, 1909 Tennessee Yrs. 413-12-9338 101 **Director** Usual Residence of Decedent if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified <u>at.</u> 10d. Inside City Limits 10c. City, Town or Location Director Pikesville 1 Yes 2X No Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States Funeral 21208 602 McHenry Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 ♥ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker 8 Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lettie Eads Warren Leslie Harpe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Let N. Page 1 and 2 sho Department of Health and 1 Important: If item 27 ** any injury or r** 19a. Informant's Name/Relationship (Type, Print) 7117 Liberty Rd., Gwynn Oak, MD 21207 Brenda Shipton / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 12/14/2010 Metro Crematory Inc 22. Name and Address of Facility Cremation Society of Maryland Signature of Funeral Service Licensee Alyson Taylor 299 Frederick Rd., Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CHULE CYSTITIS Physician/ WEEKS disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): ysician and e burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 1 Yes 2 2 g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETES MELLITUS CHRONIC KIDNEY DISEASE 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? ATHEROSCLEROTIC HEART DISEASE, 24a. Was an performed? Yes 2 No HEART FAILURE, ATRIAL FIBRILL ATION 1 Yes 2 No CONGESTIVE 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after death. 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier D 57444 MO 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21284 10w sar 19099 W. CHEN MO HLEXANDER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day Year **Physician** Frederick Garfinkel 15 3010 Decemb /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year)
July 31,1931 If Under 1 Year If Under 24 Hrs. 9. Birthpla 7. Age (In yrs. last birthday) tate or Foreign **Funeral** 1X M 2□ F Months Days Hours Min. Country. Branx, New York Director Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐Yes 2 No Director Maryland Harford Bel Air 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21015 150 Royal Oak Drive United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed by 3 Widowed 4 Divorced natural" traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within College (1-4or 5+) Is marked other than Elementary/Secondary (0-12) 12 4 Management Shoe Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental þe William M. Garfinkel Sonia Tulipmen ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other tra Diana Garfinkel (Spouse) 150 Royal Oak Drive Apt. E Bel Air, Maryland 21015 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State The Cheb Shalom Memorial 15, 2010 Reisterstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
Evans Funeral Chapel & Cremation Services-Parkville
8800 Harford Road Parkville, Maryland 21234 Signature of Feneral Service Licensee 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Miller **Physician** disease or condition resulting in death) /Medical or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of) physician the burial Box 68760. Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No Ö 9 I Unknown ₫. 23e. Did tobacco use contribute to the cause of death? Part II)Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown should I /24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed? cate has 2 No certificate 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes⁄ 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Pending within 24 hours arter common to the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and title of certifier

Day, Year

2010 4

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

10-Bri

-09516		Please Type or Print in Black Indelible Ink. Ensure All	Copies	Are Le	gible.	
an M Goscins		State of Maryland / Department of Health and Mei 1- For State Certificate of Death Registrar		F	Reg. No.	10 39309
Physicia edical Exami		1. Decedent's Name (First, Middle,Last) Brian M. Goscinski		Date of Dea Month Decembe	ath Day Yea er 11, 2010	3. Time of Death 0031 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location University Hospital Baltimore	of Death		4c. County of	of Death
Funeral Director		5. Social Security Number 216-74-8366 6. Sex 17. Age (In yrs. last birthday) 53 Months Days Hour	_		irth(MM/DD/YYYY /1957	Birthplace (State or Foreign MD Country)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director		in, Puerto Ric y: e kind of work T use retired er's Name (Fi	ify Yes or Nican, etc.) k done) irst, Middle, And	Specify: Self-e Maiden Surname)	- American Indian, Black, , etc. White siness/Industry mployed
	Ē	Cheryl Goscinski / Daughter 408 Neepier Rd., 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee M01452 22. Name and Address of Facilia Bailey Funeral 4023 Annapolis 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as	Catons 12/13 12/13 Home Rd.,	and C	20c. Location - Odento Cremation Chorpe, M	28 City or Town, State n, MD Service, PA D 21227
Physician /Medical :xaminer		Failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Both territer the inductors that caused the death. Both territer the inductor dying, such as failure. List only one cause on each line. Both territer the inductors that caused the death. Both territer the inductors that caused the death. Both territer the inductor dying, such as failure. List only one cause on each line. Both territer the inductors that caused the death. Both territer the inductor dying, such as failure. List only one cause on each line. Both territer the inductors that caused the death. Both territer the inductors that caused the dea	caldiac of re	spiratory an	rest, shock, of the	Between Onset and Death
S se L	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):				
e executed sian and rial - transit	ह	UNPENDED MANAGED#23a,ptII,perME,G910,12/27/	′2010.V	WS		
Box 68760, e death certificate be exemple attending physician ed for use as the burial -	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy	oic pregnancy		23d. Date of o Month	delivery Day Year
that the do	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P	Part I.			oute to the cause of death? Probably 4 Unknown
of Vital Records, P.C. g. Physician: The law requires that ther this certificate has been signed I neral director, page 2 should be dete	Completed	Methadone And Cocaine Use		24a. Was autoj	an 24b. W psy pr prmed? de	/ere autopsy findings available for to completion of cause of path? Yes 2 No
ital Recions The scertificate rector, page	BB B	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other4	_		Residence 6	Other:
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Certification: To	1 ✓ Yes 2 No Impatient 2 ✓ EVOutpatient 3 DOA 4 27. Manner of Death 1 ✓ Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 4 Homicide Could not be determined (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 2 28c. Injury at Wor 1 Yes 2 2 28e. Place of Injury - At home, farm, street, factory, office building, expecify)	No	d. Describe	how injury occurre	
To the Hospi within 24 hou To the Funer completely fil	Medical Co	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.				
To Wit	Me	and manner stated. 29b. Signature and title of certifier 29c. License number	г		29d. Date signe	d (Month, Day, Year)
		Voujonte Brelkrill O.C.M.E.			December 1	11, 2010
\		30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street. Baltimore	e. MD 212	201		

State 31. Ed (ed (Modifi, 24) (1.17) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 20 ÎÖ 10:10 P M Physician/ Dec. Henry B. Gerk Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Age (In vrs. last birthday) (Month, Day, Yeh. 20 Funeral Country) MD Min. Hours 1 ★ M 2 □ F Feb. 78 Director 218-28-6872 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov 10b. County 10a. State be filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Timonium Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21093 320 Kimrick Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces Black White etc. 1 Never Married 2 X Married 1X Yes 2 No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 Widowed 4 Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Dept. of Transportation Federal Court Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) ပ Barbara Loring Frederick Gerk permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke, any injury or other traumatic & once. traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 320 Kimrick Place, Timonium, MD 21093 Mrs. Mary I. Gerk/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2X Cremation 3 Removal from State 12/13/10 Glen Burnie, MD Atlantic Crematory 4 Donation 5 Other (Specify) 22 Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 The Mire of Funeral Service Sicposee Michael J. Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onserpand Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examin the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last rate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 200 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes certificate 25. Was case referred to medica 26. Place of Death (Check only one) director, Be examiner? Hospital Other: (è 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes After this the funeral Magner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; Af completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie XI 23a) (Type, Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 11 Physician/ December Da George J. Germershausen 2010 9:30 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 715 Maiden Choice Lane HV620 Catonsville Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 X M 2 🗆 F Months Hours 214-22-9153 **Director** 84 Maryland Usual Residence of Decedent 28a-f shov 10a. State aţ **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f si any injury or other traumatic event, the Medical Examiner must be notified. Baltimore MD Catonsville 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane HV620 21228 United States within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White Completed 3 Widowed 4 Divorced Specify: Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 Human Resources Manager Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ George Germershausen Anna Purcell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10228 Bristol Channel, Ellicott City 21042 Maryland Donald J. Pressler (Nephew) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State Bayview Crematory 4 Donation 5 Other (Specify) 12/14/2010 Baltimore, Maryland Signature of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery by the attendatached for us 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Be Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy s certificate ha performed? 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 HNo 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation after death Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) / au 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) aken W 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 2010 12:30 P M Vincent Francis Garagusi December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Suburban Hospital Bethesda Montgomery If Under 1 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) Year If Under 24 Hrs Social Security Number **Funeral** Months Hours Min (Month, Day, Yea November 24 New York 1 🔀 M 2 🗆 F Yrs. Director 103-20-9928 83 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 X No Bethesda Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 9321 Renshaw Drive 20817 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces?
1 🖾 Yes 2 🗆 No 1958-1 Never Married 2 X Married by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced 1960 Completed and Mental Hygiene.
is marked other than "natur
aumatic event, the Medical! 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Medicine Physician Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Humportant: If item 27 is markany injury or other. filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Katherine Giannone Julius Garagusi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9321 Renshaw Drive, Bethesda, Maryland 20817 Anne P. Garagusi/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Montgomery Crematorium, Inc. December 14 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Bethesda, Maryland Bethesda-Home, Chevy Chase, Inc esda, Maryland 20814 22.Name and Address of Facility Robert A. Pumphrey Funeral Home, 7557 Wisconsin Avenue, Bethesda, 21. Signatur f Funeral Servi Houm Ma M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause og ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, outemone or disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or): and I-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box (3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed plnods peen Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 No has death?
1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)

0 Vital Records, VINCEIN Division of MARAGUST

12/11/10

Be ဂ္ Certificate:

examiner?

1 Yes

27. Manner of Death

1 Natural

2 Accident
3 Suicide

4 Homicide

29a. Certifier (Check only one) 29b. Signature 20 No

5 Pending

Investigation 6 Could not be

determined

To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director After this certificate completed filled in by the funeral director, pag

Medical 11 State Registrar

	building, etc. (appearly)		ony or nown, charge
2	Certifying Physician: To the best of my knowledge, de Medical Examiner: On the basis of examination and/or is Medical Examiner: To the best of my knowled Medical Examiner: To the best of my knowled	nvestigation, in my opinion, death occurred at th	ne time, date and place, and due to the cause(s) and manner state
app	ixle of certifier	29c. License number	29d. Date sighed (Month, Day, Year)

28c. Injury at work?
1 ☐ Yes 2 ☐ No

4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of injury (Month, Day, Year)

8600 Old Georgetown Road, Bethesda, Maryland 20814 M.D. Rohatgi,

4 2010 32. Registrar's Signature

112 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office

28b. Time of

iniury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ :55 PM obert 010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomer heneral ne ontgomer. If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday, Funeral Days Hours May 21. 1 X M 2 □ F 278-24-0082 80 T930 Director Usual Residence of Decedent show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Examiner must be notified 28a-f 1 Yes 2 No Maryland Montgomery Silver Spring ö 10e, Street and Number 10g. Citizen of What Country? 23a Funeral 15115 Interlachen Drive, #514 20906 United States items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o þ 1 Never Married 2 M Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+)
5+ Federal Government Program Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic e Beatrix Lenore Wood Green Jerome Boley 20906 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15115 Interlachen Drive, #514, Silver Spring, Maryland Helen P. Green / Wife Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parklawn Memorial Park 14, 2010 Rockville, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 21. Signature of Funeral/Service Ligensee ette M01305 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death cardiopul Physician/ monax disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed burial-transit 1 etuskulic that initiated events Due to (or as a consequence of resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 performed certificate 2 🗌 No Yes 2 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 1 No 1 🗌 Yes |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury 28c. Injury at 28b. Time of Certificate: within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funera (Month, Day, Year) injury 5 Pending Natural Division 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier M.A. Maranus D71314 9/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

Manju A. Mavanur, MD

1 4 2010

31. Date filed (Month, Day, Year)

State Registrar 18101 Prince Philip Drive, Olney, Maryland 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 3. 45 PM GERTNER 010)巨 FANNIE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner RAW DALLS TOWN North West BALTIMORE 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Year Days Hours 1 □ M 2 💢 F 05/31/1921 89 LATVIA Director 213-60-6731 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f shovevent, the Modical Exeminer must be notified at 1 X Yes 2 ☐ No Director MD N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 7218 PARK HEIGHTS AVENUE Funeral 21208 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2X No Specify. à Specify: 3 ₩ Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, The Maone. Elementary/Secondary (0-12) 12 College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be YITZHAK MICHEL SANDLER UNKNOWN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MILTON GERTNER / SON 3211 MIDFIELD ROAD, BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 12/12/2010 ROSEDALE, MD 4 Denation RUDOMER VEREIN 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Jailure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit P.O. Box 68760 Due to (or as a consequence of) Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) □Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MI D69108 M.C-7 DEC, 11, 2010

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

1 4 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUBHASH BASE, 5401 Old COUST RIP, RANDALLSTOWN MID

32. Registrar's Signature

NORTHWEST HOSPITAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 12 PM eonie Medical 4c. County of Death Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Arden Courts of Towson Towson 8. Date of Birth 9. Birthplace (State or Foreign if Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** June", Par Year 924 Months Days Hours Min. 1 M 2XX 86 Yrs <u>Switzerland</u> 215-54-1404 Director Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director Towson Baltimore 1 Yes 2XX No |Maryland 10f. Zip Code 21204 10e. Street and Number 10g. Citizen of What Country? United States Funeral 8101 Bellona Avenue America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2XNo white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Carl Koeppel ၉ Hedwig Koeppel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 W. Pennsylvania Avenue Suite 606 Towson, Marylam Mr. Alexander A. Hassani/ son Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition December 14, Evans Fure al. Chapel – Bel Air 1 Burial 2XXCremation 3 Removal from State Forest Hill, Maryland 2010 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}es Funeral and Cremation Center, P.A. Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 21. Signature of uneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exam Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ... Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Pregnant at time of death within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 Tes 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) H00104267 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Dark Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HURLEY **ELEANOR FLOWERS** o compo Medical 4a. Facility Name (if not institution, give street and number Town, or Location of Death 4c. County of Death Examiner None Da TIMONE 7 move If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Min. 1 □ M 2/XF Hours 0777027119719 MaryYand 91 577-20-4693 **Director** Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 XXVo Baltimore Baltimore Marvland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21212 709 Murdock Road USA should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 X X Married TENT FINDWILL WAS 15. Maryland 21215-0036 1 ☐ Yes 2 🛣 🗓 o If Yes, Give Specify Specify. 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. tem 27 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Clerk Baltimore County permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Patterson Flowers Nellie Laing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 709 Murdock Road Baltimore, Marvland 21212 Winton Frederick Hurley Husband 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 12/13/2010 Greenmount Cemetery Donation 5 Other (Specify) |Hillsboro, Maryland onature of Fun-22. Name and Address of F神社chell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ days disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury that the death certificate be executed burial-trar that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown detached for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day Year the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by be Steo porosis Hospital or Attending Physician: The law requires 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2 No certificate Yes 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home 5 \sum Residence 6 \sum Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work after death. 1 Yes 2 No Accident
Suicide Investigation the 6 Could not be within 24 hours after de
To the Funeral Directo
completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 12/16/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Singh 2401 W. Belvelere Ave. Bultimore . Registrar's Signature State 2010 Registrar

Known as Hulley Gleanor

lease	Type or	Print in	Black	Indelible	lnk.	Ensure All	Copies A	re Le	gible.	
								,		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 44 PM Physician/ Month Š 2010 Ronald Helewicz Μ. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Ko + 1 MOTE 5. Social Security Number Birthplace (State or Foreign Country) Funeral Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 ☐ M 2 ☐ F (Month, Day, Year) 01/29/1949 Days Director 218 54 2793 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Maryland Baltimore 1 🗌 Yes 2 🖵 No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 336 Wye Road 21221 "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗆 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates. Vietnam Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Disabled Disabled Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanley Helewicz Lillian Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Helewicz (wife) 336 Wye Road Essex Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Gardens of Faith Cem 12/16/2010 Ovelea Maryland 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.
Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) DIS ease Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transi Lause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 No Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 10063327 12/10/ WOLDETHINUT 8× 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin WOLDEHIND anis Square Drive

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State of N	/larylar		artmen <i>tificate</i>			ınd Me	-	_	201	0	393	18
			Registrar 1. Decedent's Name	e (First, Middle, La	st)		007	incare		- Catiri	- 1:	2. Date of Dea				3. Time of Dea	ath
	Physicia Medic		William		ssell	Hur	d, J	r.				Decemb		12, 201		3:44 E	ЭМ
4	Examir	er		not institution, give st Hospi	e street and number)			-	Town, or 7SON	Location of	f Death			o. County of De Baltimo			
	Funeral		5. Social Security No	umber 6.5	Sex 7. A	ge (In yrs. i	ast birthday)	If Under Months		If Under 2 Hours	4 Hrs.	8. Date of Birt	th	9. B	irthplac	e (State or Fo	reign
	Director	ı	214-38- Usual Residence of	3209	⊠ M 2 □ F	(59 Yrs.	WORLINS	Days	Hours	IVIIII.	02/21/	194	1 Ma	ary1	and	
	and show at	٥	10a. State	10b. County		10c. Cit	y, Town or Loc	cation			·				10d.	Inside City Li	mits
	Maryl 28a-f otified	irect	MD	Baltim	ore	R	osedal	е								1 🗌 Yes 2 🏿	√ No
	th the 3a or t be n	a D	10e. Street and Nun	nber incess D	rivo			10f. Zip	Code				_	itizen of What (Country?	•	
	eath wi	Funeral Director	11. Marital Status	Tricess D	12. Was Decedent	Ever in U.	S. 13. V			spanic Origi	in? (Speci	fy Yes or No- can, etc.)		.S.A.	nerican I	ndian.	
98	fter de , or it amine	2		ied 2 X Married	Armed Forces 1 Yes 2 If Yes, Give	? No		Yes, spec			Puerto Ri	can, etc.)		Black, Wh	ite, etc.	,	
Ş	ours a atural' sal Ex	Completed	3 Widowed	4 U Divorced 15. Decedent's E	Year or Dates.		16a. Deced						401	Specify: W			
215	n 72 h an "na Media	du	(Spe	cify only highest gi	rade completed) College (1-4 or	5+)	i (Give k	ind of wor NOT use	k done d	uring most	of working	,	1615. r	Kind of Busines	s indust	ry	
21,	l withi ygiene her th	Be Co	12				S ⁻	teel	Work					Steel			
Maryland 21215-0036	oe filec intal H ced ot cesor	To B	17. Father's Name (F		77.2	~ ~					,	First, Middle,	Maiden	,			
ary.	nould the ord Me simark		19a. Informant's Na		Type, Print)	<u>ta</u>	19b. Mailin	a Address	(Street a	Elea nd Number		Route Numbe	r. Citv o	Presto r Town, State, 2		e)	
Ž	nd 2 sh salth a nn 27 is ertra		Margare	t Hurd /	Wife									MD 212			
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			Cremation 3	Removal from Stat		Place of Dispos cemetery, crem	sition <i>(Nan</i> natory or o	ne of ther place		Da		20c. L	ocation - City o	or Town,	State	
Ħ	artmer ortant injury		4 🔀 Donation 21. Signature of Fu	5 Other (Speci	*	Ana	atany Gii		-	y 1 s of Facility		/2010		nover, ts Regi			
Ba	Department of the second of th		21. Signature of the	SO E	1		1					-		Hanover	4		5
	13.5		23a. Part 1. Enter to shock, or hear	he disease, or com	plications that cause one cause on each li	ed the deat	h. Do not ente	r the mode	e of dying	, such as c	ardiac or ı	respiratory arr	est,		Ap	proximate erval Betweer	n
4	Physician/		Immediate Cause (I disease or conditio resulting in death)		a Adva	wood	Pa	ule	W 20	س	dis	eare	_			set and Death	n
	Medical Examiner		resulting in death)	ſ	Due to (or as	a consequ	uence of):								1		
		iner	Sequentially list con if any, leading to im cause. Enter Under	mediate	b. Due to (or as	a consequ	uence of):										
. 4-	cuted .nd transit	Examiner	Cause (Disease or i that initiated events	linjury	c. —												
Mp	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	al E	resulting in death) L	_ast	Due to (or as	s a consequ	uence ot):										
120	icate by physics the b	ledical			d								-				
Вох 68	ending use a	an/N	IF FEMALE: 23b. Was decedent		23c. If yes, outcom			Ectopic p	oregnancy	,			d	23d. Date of d	elivery		
	death	Physician/M	in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	4 Pregnant 9 Unknown	at time of		Other (sp						Month	Day	/ Year	
Division of Vital Records, P.O.	at the			icant conditions	contributing to death	but not res	sulting in the u	nderlying o	ause giv	en in Part I.		23e. Did to	bacco	use contribute	to the ca	ause of death	?
IS, F	uires ti n signi lid be	ed by										1 🗆 ,	Yes 2	X No 3 □	Probabl	y 4 🗌 Unkr	nown
S	av requals bee	plet										24a. Was a		24b. Were a	utopsy to	findings availa	able of
Rec	The la	Completed										perfo	rmed?	death?	es 2 🗆	_	
ta	certific	Be	25. Was case referre examiner? 1 Yes 2	_	Hospital:				Othe	ce of Death				h	+ .	3.4	
of V	g Physer this	e: To	27. Manner of Death)	1 □ Inpa 28a. Date of in (Month, D	ury	28b. Time of injury		8c. Injury	4 □ Nur at		e 5 ∐ Resid d. Describe h		Other (Spery occurred	cify)	toxpic	9
on	eath. or: Afti	ficat	1 XNatural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending Investigatio 6 ☐ Could not b	n			М		yes 2□1	No						
N S	or Att after d Direct in by	Certificate:	4 Homicide	determined	28e. Place of in	jury - At ho tc. <i>(Specif</i>)	ome, farm, stre	et, factory	, office		28	If. Location (S City or Tow		nd Number or R e)	ural Rou	ite Number,	
Ω	spital				rsician: To the best o												
(10)	the Ho lin 24 I the Fu	Medical	Softy one) 3	Gertifying Nur	niner: On the basis of se Practioner: To the	examination	n and/or investi y knewledge, d	seth Joour	nad et the	time, data a	curred at the	e time, date a	nd place	e, and due to the	cause(s	s) and manner	stated.
	To with		29b. Signature and	file of certifier	'n	MD		29c.	. License				29d. Da	ite signed (Mon	th, Day, j	Year)	
	1		30. Name and addre	ess of person who	completed cause of	death (Item	23a) (Tvna P	rint)	D-	401	10			12/12	-/1	O	
	Ψ		ARATHI	KUMAR	6701	NCI	nen ler	<u>s</u> \$t	, (انيه	2 6	105	Bed	lt: re	ا ب	HD 21	2011
	Sta Registra		31. Date filed (Month	2010 /	completed cause of	rar's Sign	ture										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 13 Day 2010 Year Physician/ 9:30A M Stephen Anthony Horn Dec Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3346 Sykesville Rd. Westminster Carroll 9. Birthplace (State or Foreign MD Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min. 1 🔀 M 2 🗆 F Hours 218-40-1914 70 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Marker. Director 10a. State 10c. City, Town or Location 10d. Inside City Limits Westminster MD Carroll 1 ☐ Yes 2 🛂 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3346 Sykesville Rd. 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Tool Machinist 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Joseph Horn Mary C. Huber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Ogle-daughter 2238 Cherokee Dr., Westminster, MD 21157 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place).

Evergreen Memorial 12-17-10 Burial 2 ☐ Cremation 3 ☐ Removal from State Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home 21. Signature of Furreral Service License homes 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. . Do not enter the mode of dying such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine thany, leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Vear Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy nerformed death? 2 \square No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 💢 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death

1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 5 Pending 2 🗆 No 1 Yes 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

DHMH 17 Rev 7/2009

State Registr<u>ar</u> 4/W

BALTIMORD Bul)

Idress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland	/ Depa	rtment of H tificate of D	lealth and M			10	39320
			Registrar 1. Decedent's Name (First, Middle, Last)	Ceri	illicate of D	eain	2. Date of Dea	Reg. No.		3. Time of Death
	Physicia	n/	Eunice Mae Hope				Dec 1	Day	Year	2:00 A M
-	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	Dec 1.	4c. County		12.0021
	LAGIIIII	CI	2127 Herbert Ave.			ninster			roll	
	Funeral	n.	5. Social Security Number 6. Sex 7. Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	h	9. Birth	place (State or Foreign
	Director		216-20-9613 1 M 2 XF 83	Yrs.	Months Days	Hours Min.	7-2-19	927	MD_	ury)
	nd now at	_	Usual Residence of Decedent 10a, State 10b, County 10c, City,	Town or Loc	ation				1	10d. Inside City Limits
	arylar a-fst fied	ecto	MD Carroll			minster				1 ☐ Yes 2 🛣 No
	or 28 or 28 e noti	Dir	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Cour	ntry?
	with t	Funeral Director	2127 Herbert Ave.		211	157		USA		
	leath items er mi	Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	/as Decedent of His	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No-		e - Americ	
တ္ထ	ifter d ", or i amin		1 Never Married 2 Married 1 Yes 2 Mo		Yes 2 No		nican, ctc.,		ck, White, : whi t	
Š	ours a	Completed by	3 Widowed 4 Divorced Year or Dates.							
Ċ	72 hennamena	nple	(Specify only highest grade completed)	(Give k	ent's Usual Occupa ind of work done d ONOT use retired)	uring most of worki	ng	16b. Kind of B		ŕ
212	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at	Co	Elementary/Seconday (0-12) College (1-4 or 5+) 1 2 2	Custo	mer Rel	ations		Gas &	Elec	ctric
Maryland 21215-0036	라 당 술 달	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle,	Maiden Surnam	e)	
<u> </u>	lid be fill Mental larked atic ev	₽	Webster Ford Elliott			Mildred	Baffo	rd		
Jar	1 and 2 should be fil if Health and Mental item 27 is marked other traumatic ev	0 0	19a. Informant's Name/Relationship (Type, Print)			and Number or Rura		•		
	and 2: Health :em 27 ther tr				Herbert	Ave.,W	estmin Date	ster, N 20c. Location		
Baltimore,	Page 1 nent of ant: If it ury or o				the section	em 12-1		Westmi		
틀	nit. Paartme ortan injury	Ŋ	4 Donation 5 Other (Specify) 21. Signatury 31 Funeral Service Licensee	22	Name and Addres	s of FacilityFle	tcher			
g	permit. Page 1 a Department of H Important: If itel any injury or oth	0 H	I Thomas D. Flatin In			in St.,				
			23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each lipe.	Do not ente	r the mode of dying	g, such as cardiac o	r respiratory arr	est,		Approximate Interval Between
-+	hysician,	8 3	Immediate Cause (Final disease or condition	CIUS	Jal 1	Swews				Onset and Death
	Medical Examiner		resulting in death) a. Due to (or as a consequence)							- 90
	Examine	<u>.</u>	Sequentially list conditions, b.						_	
_	sit sit	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	ence of):					21	
	executed an and rial-transi	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence)	ence of):			·			
_	ate be executed physician and the burial-transit	dical								
3/60	ficate g phy as the	Nedi								
/20 >	endin use	an/h	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal		Ectopic pregnance	v			ate of deliv	
Box	death	sici	in the past 12 more is? 1 Yes 2 No 9 Unknown 9 Unknown		Other (specify)			Mo	onth	Day Year
5	at the d by ti etach	Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resu	lting in the ur	nderlying cause giv	en in Part I.	23e Did to	phacco use conf	tribute to t	he cause of death?
 J	signe d be d	d by	Perioheral Arterial	A			1 🖭			bably 4 ☐ Unknown
ğ	requii been should	lete					24a. Was a	an 24b.	Were auto	psy findings available
Division of Vital Records,	e law e has ige 2 :	dmo					autop	rmed?	prior to co death?	impletion of cause of
<u>r</u>	un: Th ifficate or, pa	Be Co	25. Was case referred to medical		26. Pla	ace of Death (Check	1 Tyes	2 LIV No	1 🗌 Yes	2 🗆 No
Ĭ,	ysicis is cert direct	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 E	R/Outpatien	t 3 DOA Othe	er: 4 🗌 Nursing Ho	me 5 Resid	lence 6 🗆 Oth	er (Specify	()
ō	ng Ph ter th neral		27. Manner of Death 1 Natural 5 Pending (Month, Day, Year)	28b. Time of injury	28c. Injury work	at		ow injury occur		
ĕ	tendii leath. or; Ai the fu	ifice	2 Accident Investigation			Yes 2 No				
<u>≥</u>	or A: after of Direct in by	Certificate:	4 Homicide determined 28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Tow		er or Rura	l Route Number,
٦	spital		29a. Certifier 1 Certifying Physician: To the best of my knowle	dge, death o	ccured at the time.	date and place, and	d due to the cau	use(s) and mann	er as state	ed.
	To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death certificate has been signed by the attending physicis to the tuneral Director. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn	Medical	(Check only one) 3 Certifying Nurse Practioner: To the best of my	and/or investi	gation, in my opinio	n, death occurred at	the time, date a	nd place, and du	e to the ca	use(s) and manner stated.
	To th Comp		29b. Signature and title of certifier	<u> </u>	29c. License	number		29d. Date signe	d (Month,	Day, Year)
			+ 1 trans 1. Galis	Tu	1)3	31660		12/1	3/30	10
)			30. Name and address of person who completed cause of death (Item 2	23a) (Type, P	rint)	Nevve	LALDER	araste.	1 100	aculand
	-0:-		THOMAS K. GALUW III MM 3 31. Date filed (Month, Day, Year) 32. Registrar's Signatu	· · · · · · · · · · · · · · · · · · ·	TUDUTEL	1000104	VUT 311	1.1.7		V 616
	Sta Registra		DEC 1 4 2010 Several A.	park						
									_	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Physician/ Day E 10:32 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Baltimore Medica of Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) **Funeral** Dec. 5.1958 Days Hours Min. 1 X M 2 □ F Director 219-68-1465 51 Usual Residence of Decedent 3a or 28a-f show t be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items 23a or 28a-f shor jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1xx Yes 2 ☐ No Baltimore MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21223 USA 339 S. Bentalou 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **Automobile** <u>Mechanic</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald L. Hoyle Anna Imbrogulio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 339 S. Bentalou Street, Baltimore Maryland 21223 Belinda Hoyle-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec. 15,2010 Glen Burnie MD Atlantic Crematory 21. Signatur, of Juneral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home Inc. 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ionomiu Medical resulting in death) Due o (or as consequence of Examiner Cuito Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by liver disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2X No 1 🗆 Yes 은 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier LA Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated re and title of certifier 29d. Date signed (Month, Day, Year) 1093030553 12/10/10 rson who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Michael

31. Date filed (Ment

Greene

32. Registrar's Signature

Street

Battimore, MO 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 39322 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deal 3. Time of Death Physician/ 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 1445 Watts Avenue Severn 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) Country) 14 M 2 □ F Director 219-32-6430 74 May 6,1936 Maryland Usual Residence of Decedent Department of Health and Mental Hygiene. Important: I fitems 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical or 28a-f show 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Anne Arundel MD Severn 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 1445 Watts Avenue 21144 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No UNK Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Entertainment Hall Custodian Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Elizabeth H. Wright Llewellyn C. Ireland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June S. Ecker / Daughter 603 Ashington Rd., Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 🗆 Burial 🏻 Cremation 3 🗆 Removal from State Metro Crematory Inc 12/15/2010 |Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Alyson Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has the irector, page 2 s autonsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at nours after death. neral Director; After ti I filled in by the funera Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pendina Accident Investigation 2 Accident
3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier License number Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

GHTFOOL

32. Registrar's Signature

ENSE HWY, ANNAPOLIS, M.D. 2140

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #10e Per FH G910 12/14/10 JH
State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		Certificate of Death	Red	g. No.	C. D. W. S.
74	Physici	an/	1. Decedent's Name (First, Middle, Last	(1)		2. Date of Death Month		3. Time of Death
\$	Med	cal	DELORES G 4a. Facility Name (if not institution, give s			December	Day Year 9 2010	1615 PM
اسروا	Exami بر	ner			4b. City, Town, or Location of Deat	th	4c. County of Deat	
	Funeral	Г	Social Security Number 6. Security Number	X 7. Age (In yrs. last birtho		8. Date of Birth	BALTIMO 9 Bir	R.s. thplace (State or Foreign
	Director		2(28.421)	JM 2 XF 7/ Y	rs, Months Days Hours Min.	(Month, Day, Ye	39 Co	untry) MD
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location			
	faryla Ba-f s tified	Director	MD Battir		dallstown			10d. Inside City Limits 1 ☐ Yes 2 📈 No
	the N	ā	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Co	
	h with 1s 23; nust l	Funeral	4905 luiser	neve Road	21133		US	
	r deat or iten iiner i		11. Marital Status 1 Never Married 2 Married	Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
21215-0036	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at	ed by	3 Widowed 4 Divorced	1 ☐ Yes 2 ▼No If Yes, Give Year or Dates.	1 Yes 2 No Specify:	,		ack
5-0	2 hour	Completed	15. Decedent's Edu (Specify only highest grad	ucation 16a. D	ecedent's Usual Occupation	16	Sb. Kind of Business I	
121	thin 7 ene. than	moS	Elementary/Seconday (0-12)	College (1-4 or 5+)	Rive kind of work done during most of worke. DO NOT use retired)	rking	Public S	
d 2	lled w I Hygi other	Be	17. Father's Name (First, Middle, Last)	5t years	<u>Educator</u>	me (First, Middle, Maid		
Maryland	ould be filed within 7, ind Mental Hygiene. marked other than matic event, the Me	은	Joseph Gladder	n, Sr.	ISAL		od ward	
lan	should and Me is mar raumati		19a. Informant's Name/Relationship (Typ		lailing Address (Street and Number or Ru	ral Route Number Cit	ty or Town State Zin	Code)
e,	and 2 Health em 27 ther tr		20a. Method of Disposition	Si Sr. / Husbund 9-	705 Tulsemere H	ad fundo	allistaun M	10 21133
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highly or other traumatic event, the Medical Examiner must be notified at once.		1 → Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State cemetery,	isposition (Name of crematory or other place)		c. Location - City or	
a E	permit. Page Department Important: I any injury or once.		21. Signature of Funeral Service Licenses	- I MALLIUS	Memorial Park 12/11 22. Name and Address of Facility Va			
ñ	an,		Daughe C.	X ·	8728 Liberty Roa	akanda	USTAN M	D 21132
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one	cations that caused the death. Do not cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
·F	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	Small Bowel Due to (or as a consequence of):	obstruction			Onset and Death
	Examiner			Due to (or as a consequence of):				
	_	iner	Sequentially list conditions, if any, leading to immediate cause. Enter oncertying	Due to (or as a consequence of):	Instarcinona			
ζ,	scuted and transit	Examiner	Cause (Disease or linjury that initiated events c.					
_	certificate be executed nding physician and use as the burial-transit		resulting in death) Last	Due to (or as a consequence of):				
09/80	icate g phys is the	Medical	d					
ည် သ	ending process		meed and in programme	c. If yes, outcome of pregnancy	2 🗆 5-1		23d. Date of deliv	verv
Rox	death the att	by Physician	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4 Pregnant at time of death 9 Unknown	5 Other (specify)		Month	Day Year
л Э	at the	/ Ph	Part II. Other significant conditions cont	ributing to death but not resulting in th	e underlying cause given in Part I	22a Divi tahasa	co use contribute to t	
S,	ulres ti n signo ild be							bably 4 XUnknown
Ö	iw req	plet				24a. Was an		psy findings available
vitai Kecords,	ate ha	Completed	· · · · · · · · · · · · · · · · · · ·			autopsy performed 1 Yes 2 X	prior to co	empletion of cause of
<u>a</u>	cran: ertific ector,		25. Was case referred to medical examiner?		26. Place of Death (Check		,NO 1 Tes	ZEN NO
>	this c	은	1 ☐ Yes 2 🔀 No	spital:		ome 5 Residence	6 Other (Specify)
VISION OF	tth. : Affer e fune	Certificate:	1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time injury		28d. Describe how in	jury occurred	
	er deg	ertifi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm,		28f. Location (Street	and Number or Rum	Route Number
<u>ַ</u> בַּ	urs aft ral Dir lled in			building, etc. (Specify)		City or Town, Sta	ate)	
H	Fune eted fi	Medical	(Circon 2 in Medical Examiner	: Of the pasis of examination and/or inv	h occured at the time, date and place, an estigation, in my opinion, death occurred at	the time date and al-	1 1 - 1	4.3
To the	To use nospital or Autenting Proysician: The law requires that the death cert within 24th bours after death. To the Euneral Director, After this certificate has been signed by the attendin completed filled in by the funeral director, page 2 should be detached for use.		only one) 3 ☐ Certifying Nurse F 29b. Signature and title of certifier	ractioner: To the best of my knowledge	e, death occurred at the time, date and place	e, and due to the caus	se(s) and manner as sta Date signed (Month, L	ated.
			1 09 Frank	mp	D0059736			. ,
	(0)		30. Name and address of person who com	<u> </u>	, Print)		ecember 9	2010
			Deborah FHzparick 1. Date filed (Month, Day, Year)	M.D. NURTHWE	ST HOSPITAL 5401	OLD COUR	T ROAD	
	State Registra	-	NFC 1 4 2010	32. Registrar's Signature	tel .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death Physician/ Medical Name (if not institution, give street and number) 4h City Town or Location of Death 4c. County of Death **Examiner** If Unde 7. Age (In yrs, last birthday) 8. Date of Birth Birthplace (State or Foreign Funeral Months Min 1**X**M 2 □ F **Director** or 28a-f shov 10a. State 10b. County with the Maryland Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Res 2 No more De. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a death v 12. Was Decedent Ever in U.S. Armed Forces?
Yes 2 \(\subseteq \) No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, White, etc 1 Never Married 2 Married 3 Widowed 4 Divorced ģ Baltimore, Maryland 21215-0036 lines, Give Year or Dates. 1 🗌 Yes 2 No Specify. Completed injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 is marked other than College (1-4 or 5+) Be Page 1 and 2 should be filed 17. Father's er's Name (First, Middle, Maiden Surname) onas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item DECEMBER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Burial 2 Cremation 3 Removal from State 1 Burial 2 ☐ Cremation 5 ☐ . . . 4 ☐ Donation 5 ☐ Other (Specify) Dinas Mills 21. Signature of Funeral Serv Con Licensee Mo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) PANCREATIC CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or linjury To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE es, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached to Division of Vital Records, P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. ROBERT JONES 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' After this certificate 2 🗌 No Yes 2 X No Yes 25. Was case referred to medical director, æ 26. Place of Death (Check only one) Other: 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JUNECIA WHITE, CRNP TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 - State Hegistrar		tificate of L		, 0	g. No.	10 2022
	Physicia Medic		Decedent's Name (First, Middle, Last) Catherine Ki	ng			2. Date of Death Month	ec ^{Day} , 2010 ^{Year}	3. Time of Death 1:00 PM
	' Examir		4a. Facility Name (if not institution, give street and number) 9322 Farewell Rd.		4b. City, Town, or	r Location of Death		4c. County of Dea	
	Funeral Director		5. Social Security Number 144-24-0279 6. Sex 1 \(\triangle \) M 2 \(\triangle \) F 7. Age (In yrs. last 80	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Dec 2	(ear) 9. B	irthplace (State or Foreign ountry)
	yland •f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, New Jersey 10b. The county 10c. City,	Town or Loc	eation	Elizab	eth		10d. Inside City Limits
	h the Mar sa or 28a- be notifi	Funeral Director	10e.8195 aPlears Street 3E		10f. Zip Code	O7202	10g. Citizen of What Country?		
	death wit items 23 ner must		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	/as Decedent of Hi	ispanic Origin? (Spen, Mexican, Puerto	ecify Yes or No-	14. Race - Am	
0036	urs after tural", or al Examii	ted by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.		Yes 2 No		Thoun, etc.,	Specify: Specify:	lack
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12	(Give ki	NOT use retired)	ation during most of work ervice Work	ing	6b. Kind of Business	s Industry
and 2	be filed wi ntal Hygie ed other event, tl	To Be (17. Father's Name (First, Middle, Last) Joseph Mills Baker		7 00141 0		e (First, Middle, Ma		
lary	should to and Me is mark aumatic		19a. Informant's Name/Relationship (Type, Print)				al Route Number, C	ity or Town, State, Z	
re, N	1 and 2 of Health item 27 other tr			ce of Dispos	sition (Name of	t. #C7C Eas		J 07017 0c. Location - City o	r Town, State
Itimo	it. Page intment c intant: If injury or		4 ☐ Donation 5 ☐ Other (Specify)	Rosemor	atory or other plac nt Memorial P	ark DrC.	15,2010 8	lisabeth	nJ
Ba	Depa Impo any i		21. Signature of Fundral Service Licens Explanation of Moss's	22.	Name and Addres Slack Fi 3871 Ol	s of Facility uneral Home, d Columbia P	P.A. ike Ellicott Cit	ty, MD 21043	<i>V</i>)
-	Physician/		,	Approximate Interval Between Onset and Death					
	Examiner	ar	resulting in death) Due to (or as a consequent sequentially list conditions, if any, leading to immediate b. Due to (or as a consequent sequent sequ	ce of):					
B	outed nd ransit	Examiner	Cause. Directlying Cause (Disease or iinjury that initiated events C.						
0	aath certificate be executed attending physician and for use as the burial-transit	Medical E	resulting in death) Last Due to (or as a consequent d	.ce of):					
68760	certificat nding ph use as th	n/Mec	IF FEMALE: 23b. Was decedent pregrant 23c. If yes, outcome of pregnancy					23d. Date of de	alivany
Box	the death by the atte	Physician/N	in the past 12 months? 1		Ectopic pregnancy Other (specify)	y 		Month	Day Year
ls, P.C	uires that i n signed b	2	Part II. Other significant conditions contributing to death but not resulting	ng in the und	derlying cause give	en in Part I.			o the cause of death?
ecorc	ne law req e has bee age 2 shou	Completed					24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
ital F	Physician: The law this certificate has al director, page 2 !	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		Otho	ce of Death (Check		-	s 2 No Secondary
n of V	ing Phys n. After this funeral di	ate: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28	NOutpatient b. Time of injury	3 □ DOA 28c. Injury work?	4 □ Nursing Ho	me 5 A Residence 28d. Describe how	ce 6 Other (Specinjury occurred	Residence
Division of Vital Records, P.O. Box 6	Cause (Disease or lighty that inhide devents resulting in death) Last C. Due to (or as a consequence of): d								ıral Route Number,
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							causeds) and manner stated		
	To th withir Comp		29b. Signature and title of Certifier	_mouge, ue	29c. License	number	29d	. Date signed (Mont	h. Dav. Year)
	10	-	30. Name and address of person who completed cause of death (Item 23)	1	nt)	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	4	ream 62/	10,2010
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature	+ v + a	11	(0 / 0/	16 ic, 1	eryland	21044
	Registra	r	DEC 1 4 2010 A . A	ha de	9				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 45 M Medical 4a Facility Name (if not institution, give street and number) Examiner 4c. County of Death Y If Under 1 **Funeral** 7. Age (In vrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Months Days 09/23/1921 Country) **Director** 212-16-2435 89 Yrs MD Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits MD HOWARD COLUMBIA 1 Yes 2 No 10e, Street and Number P 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 10725 BRIDLEREIN TERRACE 21044 USA 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Midowed 4 ☐ Divorced Completed Specify: Year or Dates WHITE Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 MECHANIC AUTO INDUSTRY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Mental Important: If item 27 is marked any injury or other transponse. ည HARRY KOPPEL **GERTRUDE** MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARRY KOPPEL / SON 10725 BRIDLEREIN TERRACE, COLUMBIA, MD 21044 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of ANSHEY, FAUNAH other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/13/2010 AITZ CHAIM CONG. BALTIMORE, MD 21 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any local green immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and the after this character, page 2 should be detached for use as the bunal-transit lied in by the funeral director, page 2 should be detached for use as the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month 2 No 9 🗌 Unknown but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy perform Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita 2XNo မ 1 🗌 Yes Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 🗌 Yes 2 🗆 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name and addre of person who compl of death (Item 23a) (Type, Print) leted cause ے 31. Date filed (Month, Day, Year) State 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Richard W. Lambert Sr. December 3010 4a. Facility Name (if not institution, give street and number) Jown, or Location of Death County of Death eda If Under 24 Hrs If Under vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 **∑** M 2 □ F Months Days Hours Min. 212-36-9039 71 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Middle River 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 North Hawthorne Road 21220 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedo... Armed Forces? ♥ Yes 2 No Black, White, etc. 1 Never Married 2 Married Y☐ Yes 2 If Yes, Give Year or Dates 1 ☐ Yes 2 √ No Specify: Specify: White 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore Elementary/Seconday (0-12) College (1-4 or 5+) Electrician 2vrs Resco Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Davis Margaret Lynch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa L. Lambert /wife 21 North Hawthorne Road Balto. MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Garrison Forest 12/20/10 Owings Mills MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant

Natural

☐ Accident ☐ Suicide

4 Homicide

29a. Certifier (Check

MD

1 Yes 2 L 9 Unknown Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of injury (Month, Day, Year)

25. Was case referred to medical examiner? 1 Tes 2 No 1 Inpatient 2 VER/Outpatient 3 IDOA 27. Manuar of Death

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at

28d. Describe how injury occurred 1 🗌 Yes 2 🗌 No

Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific

5 Pending

62862

29d. Date signed (Month, Day, Year) 13/2010

Drive Baltimore MD. 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square

ano 31. Date filed (Month, Day, Year)

9000 Franklin

28b. Time of

injury

State Registrar

funeral director,

After this

neral Director: Af

within 24 hours a To the Funeral I

Be

မ

Certificate:

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #14 Per FH G911 1/03/2011 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year FOOK SHUE LEE 600 Ам 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Savar Rosedat Hospita ran Klin altmore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. Mar 28 1926 Director 84 China 151-16-8078 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Baltimore County Essex 10e. Street and Number o 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a o Funeral 89 Yew Road 21221 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. **Chinese** Armed Forces?

1 X Yes 2 \(\sigma\) No \(\bar{WW} \) I þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12 College (1-4 or 5+) Restaurant Waiter Retail Food Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Tong Wong Nyan Sun Tom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ngan Yeu Tam Lee (Wife) Yew Road, Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XI Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Lorraine Pk Cemetery 12/14/2010 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signatur of Funeral Service and en ee

Martin io. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, 6500 York Road, Baltimore, Maryl 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician acidos metabolic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of). attending physician and for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death Unknown Year Yes 2 No g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 **V**No Yes 2 No 1 Yes eral Director: After this certific filled in by the funeral director, To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 🗌 No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🕏 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, within 24 hours a Medical 1 decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES0000 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kousalya Arunaajri 9000 Franklin Square Drive Baltimore MD 2123

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

4

37. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NHOT LANGE 0345 AM 2010 DEC Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE Baltimore City UNIVERSITY OF MARYLAND MEDICAL CENTER Social Security Number 6. Sex 1 M 2 🗆 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 06/21/1923 Maryland 216-16-9928 Director Usual Residence of Decedent show 10h County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director or 28a-f 1 Tes 2 No Maryland Anne Arundel Co. Pasadena 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a 188 Club Road 21122 United States Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. \$ 1 Never Married 2 Married If Yes, Give Year or Dates. WWII 1 ☐ Yes 2 ☐XNo Specify. 3 X Widowed 4 ☐ Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) yr. Owner/Self Employed Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lange, Sr. John Robert Della 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Michael E. Lange / Son Severna Park, MD 21146 685 Faircastle Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1X Burial 2 Cremation 3 Removal from State 12/13/2010 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Brooklyn Park, MD 21. Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral & Cremation Services PA; 1 2nd Ave SW; Glem Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only Immediate Cause (Final Onset and Death Ph_sician/ subdural hernatoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by congestive heart failure atrial fibrillation 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of hypertension, emphysema autopsy Yes 2 No 1 ☐ Yes 2 Ø No Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☑ Yes 2 ☐ No ၉ 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide iniury 5 Pending 1800 PM 1 Yes 2 No tall 02 2010 Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined At home IIB CLUB RD, PASADENA, MD Medical

Hospital or Attending Physician; The law requires that the death certificate be executed Box 68760 Records, P.O. Division of Vital

Baltimore, Maryland 21215-0036

54

State Registrar DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

BILGE DICLE KALYON, MD 22 SOUTH GREEDE ST. BALTIMORE MD 21201

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Number Franticular: To the boat of my inventoge death occurred at the time date and place and the time date and place and the time date and place.

P25607

29d. Date signed (Month, Day, Year)

DEC 09 2010

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

iancy magec		1- For State Registrar	te of Maryland / L		te of Death	ia Meritar i	_	eg. No.	5 0700
Physiciai Medical Examin	n/	 Decedent's Name (First, Middle, 	Last) lison Mage	0			Date of Deal Month	th Dav Year	3. Time of Death 2023 hrs
Mieurcai Examini		4a. Facility Name (if not institution,			4b. City, Town, o	r Location of Deat	December	7, 2010 4c. County of Dea	
·- /		Johns Hopkins Bayviev			Baltimore				
Funeral Director		218-86-7747	. Sex 7. Age (I	n yrs. last birth	day) If Under 1 Ye Months Day Yrs.			th(MM/DD/YYYY) 9. B Fore 2 , 1 9 6 9	
any .	ŀ	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town o	r Location				10d. Inside City Limits
* .	5	MD Balti	.more	Rose	edale				1 Yes 2X No
death with the Maryland or items 23a or 28a-f show unst be notified at once.	Il Director	10e. Street and Number 1538 Rosewi				237		0g. Citizen of What Cou	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23s or 28s-f she other tranmatic event, the Medical Examiner must be notified at once	Fune	11. Marital Status 1 Never Married 2 Mari 3 Widowed 4 Divor	ied 12. Was Decedent Evented Armed Forces? 1 Yes 2 X Ced If Yes, Give Year		13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 X No	in, Mexican, Puerto		- 14. Race - Ame White, etc. Specify: Wh	rican Indian, Black,
ours aft atural'	g P	15. Decedent's Education (Specif	or Dates:		ecedent's Usual Occupa	ation (Give kind of		16b. Kind of Business	/Industry
36 in 72 h han "n lical E	Completed	Elementary/Secondary (0-12) 12th	College (1-4 or 5+)	al di	uring most of working life Roofer	e. DO NOT use let	ireu)	A&B Home Improve	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than te event, the Medica	Ę.	17. Father's Name (First, Middle, L	ast)			18.Mother's Name	e (First, Middle, M	The state of the s	
1215 De file ental H orked o	8	Edgar Ray	_				ile Jer		
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. tt: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner.		19a. Informant's Name/Relationship Diana Podows		111	Mailing Address (Street 1538 Rose)	wick Av	enue Ba	altimore	MD 21237
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and IN Important: If item 27 is in injury or other traumatic.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Specific	cify:	cremator Bayv	Disposition (Name of co y or other place) LEW Crema	tory 12	Date 2 / 11 / 10	20c. Location - City o Balti	more MD
Balt permit Depart Impor	- 1	21. Signature of Funeral Service Li	1 Out		22. Name and Addres			ce Ave. B	
Physician		23a. Part I. Enter the disease, once failure. List only one cause or	proplications that caused the	death. Do not	enter the mode of dying	Jy F'une: , such as cardiac d	ral Holl or respiratory arre	NE OI ESS est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease	a. Cardiac		nmia				Death
and of	1	or condition resulting in death)	Due to (or as a conseque b. cardiomega						
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequent	ence of):					
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	ence of):					
760, cate be executed physician and he burial - transit	평-	X UNPENDED	d					· · · · · · · · · · · · · · · · · · ·	
60, ate be e hysicia e burial	Medical	IF FEMALE:	AMENDED line		27, per ME	g910 12/	16/10 TT	23d. Date of deliver	<u></u>
ox 687(eath certificate attending plear the asth		3b. Was decedent pregnant in the past 12 months?	1 Live birth	2 (Fetal death 3	Ectopic pregna	ancy		Day Year
Box 687; death certifice the attending ped for use as the	Physician/	1 Yes 2 No 9 Unkno		e or death 5	Other (Specify)				
ires that the de signed by the	2	Part II. Other significant condition	s contributing to death bu	t not resulting	in the underlying cause	given in Part I.		bacco use contribute to	
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that it is after death. at Director: After this certificate has been signed by all pirector: After this certificate has been signed by the funeral director, page 2 should be deach.							24a. Was a	2 No 3 Pro	utopsy findings available
cords, law requir has been s e 2 should l	Completed						autops perfor	sy prior to med? death?	completion of cause of
Vital Recysician: The I		25. Was case referred to medical	T		26.Plac	e of Death (Check	1 Yes 2	2 No 1 Y	es 2 No
Vita hysicia hysicia this cer	Ď	examiner? 1 ✔ Yes 2 No	Hospital: 1 Inpatient	2 ER/Out	patient 3 DOA	Other Nursin	g Home 5	Residence 6 Othe	er:
Division of pipital or Attending Phousafter death. Terral Director: After tiflled in by the funeral	- -	27. Manner of Death 1 X Natural 5 Pendin	28a. Date of Injury (Month, Day, Year)	28b. Ti		ury at Work? Yes 2 No	28d. Describe h	now injury occurred	
isio	icat	2 Accident Investig	jation 28e Place of Injury	- At home, farr	n, street, factory, office		28f. Location (S	Street and Number or Ri	ural Route Number, City
Div pital or ours after after in Tilled in	Certification:	3 Suicide 6 Could redeterm					or Town, St	tate)	
8 - = >1		(0110011011)	sician: To the best of my kn						
To t with To t	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licens			29d. Date signed (Mo	
		Carol	Halla		O.C.	M.E.		December 8, 20	10
Denna X	l	30. Name and address of person was Carol Allan, MD Assis			enn Street, Baltim	ore, MD 2120	1		
Sta Registra	te ar	31. Date filed (Month, Day Year) DEC 1 4 2010	32. Registrar's	ignature	led				
			-	1.0					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary Μ. Miinch 1:41 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Anne Arundel Battimure Washington Medical rotors If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 ☐ M 2 🔀 F Months Days Hours Min. May 25 1924 218-14-0960 86 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland aţ Director notified 28a-f 1 Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Examiner must be permit. Page 1 and 2 should be filed within 72 hours after death with. Department of Health and Mental Hygiene. Important if filem 27 is marked other thor." any injury or other traumotic. 23a Funeral 8129 Tower Bridge Drive 21122 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 Yes 2 No Specify White Specify 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bookeeper 12 Asphalt Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Ρ. Gaynor Mabel Towner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Miinch 8129 Tower Bridge Drive, Pasadena, MD 21122 (spouse) Date 17 20a. Method of Disposition 20b. Place of Disposition (Name of 20c Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec cemetery, crematory or other place) 2010 Maryland Veterans Cem Crownsville, Maryland 21. Signature o Funeral Service Lice e 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each lide. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death INFARCE Physician -11 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregpant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 month Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Tes Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 1 No ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗆 Yes 2 🗌 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif. 29c. Lice Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 175 reines

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ [□]12,2010 Terry Martin December 7:15 P.M Medical a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore County 3802 Bayville Road Middle River Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 27, 1949 9. Birthplace (State or Foreign Country) Clay Co. **Funeral** 1 X M 2 □ F Months Days Mir Hours 370-54-6128 60 Oneida, Kentucky Director Usual Residence of Decedent or 28a-f shov notified at 10b. County 10a, State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Baltimore Co. Middle River 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code ems 23a or must be r 10a. Citizen of What Country? Funeral 3802 Bayville Road 21220-3004 United States "natural", or items 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1

X Yes 2 □ No þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. **Vietnam** 1 Yes 2 No Specify. White Specify: Completed 3 Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) uth and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med Heating & Air Elementary/Seconday (0-12) College (1-4 or 5+) 12 N/A Conditioning Repairman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) age 1 and 2 should be fil ent of Health and Mental nt: If item 27 is marked by or other traumatic ew မ Paul Martin Martha Asher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs.Alexandria J.Blair (Niece) 13 Bellfalls Way Nottingham, Maryland 21236-4792 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date (Harford Co.) 1 Burial 2 X Cremation 3 Removal from State Tuesday Example of the place of the pla Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Dec. 14, 2010 Forest Hill, Maryland Cremation Services, Inc. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. 22. Name and Address of Facility

Peaceful Alternatives Funeral & Cremation Center, P.A.

2325 York Road Timonium, Maryland 21093-2215 Lic.#M00677 23a. Part 1. Interest e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ sarcoma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** equentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Dav Year 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 2 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) **DEC 1 4 2010**

DEC

D. MUNUCL

32. Registrar Signature

DOS7936

hath (Item 23a) (Type, Print) Greene St. Baltimure, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ PRESTON MORRES ON JAMES 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner FREDERICK NORTH HAMPTON NURSING HOME FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1 ☑ M 2 □ F 214-36-034 Director Usual Residence of Decedent show 10c. City, Town or Location 10a. State 10d. Inside City Limits notified at Director FREDERICK KNOXVILLE 28a-f MD 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? be AUSHERMAN ms 23a must be Funeral USA 21758 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after death 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? "natural", or i þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: BLACK Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry the M Elementary/Seconday (0-12) College (1-4 or 5+) ALUMINUM PLANT ENVIR, SPECALIST 12 TH event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental H

27 is marked of

traumatic ever ည JAMES HANR MORRISON MAUBE NAYLOR Page 1 and 2 should be nent of Health and Menta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1198 WILLOUGHBY CT. FREDERICK MO Department of Health a Important: If item 27 is any injury or other tra once. MORRISON (SON) MICHAEL 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) SMITHS BURG CREM. DEC. 14, 200 SMINISBURG 22. Name and Address of Facility GARY L. ROLLINS FUN. HUME 21. Signature of Funeral Service Licensee Rollin rang X. 110 WOST SOURT ST FREDERICK MO 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Failure Necles disease or condition Medical resulting in death) **Examiner** Actinobacter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year 5 Other (specify) 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ၉ Certificate:

Division of Vital Records, P.O. Box 68760

				1 ☐ Yes 2	No 3 Probably 4 Unknown				
				24a. Was an autopsy performed? 1 ☐ Yes 2/X No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No				
25. Was case referred to medical			26. Place of Death (Che	ck only one)					
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	spital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6							
27. Manner of Death 1		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred				
3 Suicide 6 Could not be 4 Homicide determined			ory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,				
29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									

D43091

Toll House Alle

29d. Date signed (Month, Day, Year)

12-13-2010

Frederick Mn 21701

State Registrar

82. Registrar's Signature

801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MM

Cand,

29b. Signature and title of certifier

Medical (

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 39334 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Virginia Pierre Rathie Mo₁z 2010 10:00 A M December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Transitions Health Care Sykesville Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)

July 27, 1912 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗓 F Mary land 212-34-8765 98 Director Usual Residence of Decedent 28a-f show Ħ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified Maryland Sykesville Carroll 1 X Yes 2 ☐ No ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 7309 2nd Ave. 21784 United States items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural" Completed 3 X Widowed 4 Divorced white Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Department of Health and Mental Hygiers in Important: If item 27 is marked other than 'any injury or other traumatic event, the Merone. Elementary/Seconday (0-12) College (1-4 or 5+) 12 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lewis Rathie Nellie Max 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) /irginia Madsen/daughter 327 Drummer Dr. New Oxford, PA 17350 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Mem Gard Dec. 15,2010 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) John O. Mitchell IV, Funeral Services of Dulaney Valley 200 E. Padonia Rd. Timonium, MD 21093 P.A. 21. Signature of Funeral Service Lice 23a. If rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician/ Atheros erun C disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Concertially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death been signed by the should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 🗌 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4- Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Natural injury 5 Pending after death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

Rid

-000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1AUMOUD

32. Registrar's Signature

MD

Westminst

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 11:20 PM Physician/ Maynaro Geraldine 2010 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MD Bultimore Randallstown Conter Genesis If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🗓 F (Month, Day, SEPT 8 1<u>924</u> Months Days MARYLAND 86 Yrs. Director 213-20-6012 Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location 10b. County death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 XNo RANDALLSTOWN BALTIMORE MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21133 U.S.A. 9109 LIBERTY ROAD Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.

The start is tem 27 is marked other than "natural", or any or other traumatic event, the Medical Examiting yor other traumatic event, the Medical Examiting. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK If Yes Give Completed 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) STEWART'S WAREHOUSE WAREHOUSE PERSON 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည GLADYS DORSEY unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 729 LENNOX STREET, BALTIMORE, MARYLAND 21217 Robin M. Maynard/Granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State BALTIMORE, MARYLAND 12-16-10 KING MEMORIAL PARK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
WILLIAM C BROWN COM
1206 W NORTH AVENUE 21. Signature of Fundal 9 wice bics COMMUNITY FUNERAL HOME P.A. seauce 23a. Part 1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Diabetes Physiciani disease or condition Medical resulting in death) Due to (or as a consequence of): [']Examiner Congetive Heart Sequentially list conditions, Examiner Due to (or as a consequence of) it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Lyper tension

Due to or as a consequence of): the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 Fetal death Month in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 g Yes 2 No within 24 hours after death.

To the Funeral Director, After this certificate has been signed by templeted filled in by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à stroke 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: injury (Month, Day, Year) 1 X Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DEC-13-2010 26 D71493

State Registrar Registrar's Signatu

9109 Liberty Rd., Randallstown, MD., 21133

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Farah Bozorgi, 9 31. Date filed (Month, Day, Year) **DEC 1 4 2010**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 18:50PM 2010 DECEMBE Medical **Examiner** County of Death 8. Date of Birth Month, Day, Year) Feb 7, 1942 **Funeral** 9. Birthplace (State or Foreign Maryland **Director** -40-9030 68 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location death with the Maryland must be notified at by Funeral Director 10d. Inside City Limits 28a-f 1 Yes 2 X No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 7885 Gordon Ct. 21060 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ö 1 Never Married 2 Married filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Care Giver Health Care Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be Salvatore Joseph Azzara Katherine Theresa Curreri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau <u>564 Nolview Ct.</u> <u>Joanne Pittman/Sister</u> Glen Burnie. MD 21061 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Dec 17 X Burial 2 Cremation 3 Removal from State Most Holy Reedemer 4 ☐ Donation 5 ☐ Other (Specify) 2010 Baltimore, MD 22. Name and Address of Facility Singleton Funeral & Cremation . Signature of Funeral Service Licenses Services PA 1 2nd Ave SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death AM Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner NEMON Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month 1 ☐ Yes ∠ J 9 ☐ Unknowr P.O. onditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 ☐ Nu 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital မ 1 🗀 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident 1 🗌 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 0 (30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar BACO MONE

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

-Oi CA

600

Msun

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		4	For State		State o	t Mar			rtment d ificate d			lental Hy		001	0 00007
			Registrar 1. Decedent's Name (First, Mi	iddle. Last	t)		_	Cert	incate c	Death		2. Date of De	Reg. No ath		3. Time of Death
	Physicia	n/		wborn								Month De	cemb	per 7,	
	Medic Examin		4a. Facility Name (if not institu			iber)			4b. City, Tow	n, or Location	n of Death		40	. County of E	Death
المجد			Gilchrist (Cente	r for I	Hosp	ice Car	re			owson				imore
	Funeral		5. Social Security Number	6. Se	x M 2 □ F	7. Age (Ir	yrs. last birth	nday) Yrs.	If Under 1 You Months Da	ear If Und ays Hours	er 24 Hrs. Min.	8. Date of Birl (Month, Da Aug 0	th y Year)		Birthplace (State or Foreign Country)
	Director	-	213-30-4946 Usual Residence of Decedent	5			70	115.				Aug 0	Ι,	1934	North Carolin
	show at	_ h	10a. State 10b. Cou			10	Oc. City, Town	or Loca	ation						10d. Inside City Limits
	faryla Ba-f s tified	ect	MD E	Balti	more		Tow	son							1 ☐ Yes 2 🔄 No
:	the N		10e. Street and Number						10f. Zip Co	de			10g. C	itizen of Wha	t Country?
:	h with	Funeral Director	111 West Ro	oad				T		1204	2 1-1-0 /0	aif . Van av Na			d States
	72 hours after death with the Maryland n "natura", or items 23a or 28a-f sho Aedical Examiner must be notified at		11. Marital Status 1 Never Married 2	Married	12. Was Dece Armed Fo			13. W	Yes, specify (of Hispanic C Cuban, Mexic	an, Puerto	ecify Yes or No- Rican, etc.)			American Indian, White, etc.
5	s after al", o Exam	d by	3 Widowed 4 Divo		If Yes, Giv Year or Da	e /	CYEC.	1	☐ Yes 2 🦫	No Speci	ify:			Specify:	Black
3-003c	hours natur iical I	Completed		edent's Ed		,,		Decede	ent's Usual Od ind of work do	ccupation	ast of wark	ina	16b. l	Kind of Busin	ess Industry
<u> </u>	in 72 le. han "	삥	Elementary/Seconday (0-		College (1	_		life. DO	NOT use reti	ired)	out of morni	9		a 16 1	77
7	d with lygien her ti rt, the	Be C	12	-11- 14				Bar	rber	19 14	thar's Nam	e (First, Middle,	Maiden		Employed
yland	e filed ntal H ed ot ever	To B	17. Father's Name (First, Mide James Mew	die, Last) born						18, IVIC		McCaff		(Gurriairie)	
ڇ	d Mer d Mer mark matic		19a. Informant's Name/Relat		roe. Print)		19h	Mailine	a Address (St.	reet and Nun		al Route Numbe		r Town, State	e, Zip Code)
Mar	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It of Health and Mental Hygiene. If them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Cynthia Me			ter									OC 20001
ē,	1 and of Hea item othe		20a. Method of Disposition				20b. Place of	Dispos	sition (Name o	of r place)		Date Dec 16		Location - Cit	ty or Town, State
Ë	Page nent c int: If		1 ☐ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth			State		-	Vetera		tery		<u> </u>	Owings	Mills, Maryland
Baltimore,	permit. Page 1 Department of Important: If it any injury or o		21. Signature of Funeral Serv	rice Licens	ee O AA	Mo	1443	22.	Name and A	tion an	nd Fun	eral Al	terna	atives	21296
			23a. Part 1. Enter the diseas	e, or comp	olications that	caused th	ne death. Do n	ot ente	8717 r the mode of	Green dying, such	as cardiac	or respiratory a	rest,	WSON MA	Approximate
He	nysician/		shock, or heart failure. Immediate Cause (Final	List only or	ne cause on ea	ach line.	11	0							Interval Between Onset and Death
	Medical		disease or condition resulting in death)		a. Due to	(or as a c	onsequence o	of):							
	Examiner	L	Sequentially list conditions,		h. ———										
	D ==	nine	if any, leading to immediate cause. Enter Underlying	2	Due to	(or as a c	onsequence o	of):							
	ecute and trans	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last		c. Due to	(or as a c	onsequence o	of):		-					
_	icate be executed physician and sthe burial-transit	edical		L	ld										
760	ficate g phys				u										
89	certif ending use a	an/	IF FEMALE: 23b. Was decedent pregnant	. #	23c. If yes, ou		pregnancy Fetal death	h 3 🗆	Ectopic preg	gnancy			- 1	23d. Date of	
Box	requires that the death certific been signed by the attending i should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4 ☐ Preg 9 ☐ Unk		me of death	5 🗆	Other (speci	fy)				Month	n Day Year
P.O.	at the		Part II. Other significant co	nditions or	ontributing to a	death but	not resulting i	in the u	nderlying cau	se given in P	art I.	23e. Did	tobacco	use contribu	ite to the cause of death?
ν. σ.	es this signer	Completed by	Scherop									1 🗆	Yes 2	2 □ No 3	Probably 4 Unknown
ğ	requir been s should	ete	33222	force	,,,,,							24a. Was	an	24b. We	re autopsy findings available
မင္ပ	e law e has ge 2 s	dmc										auto perf	ormed?	dea	or to completion of cause of ath? Yes 2 No
<u>=</u>	sician: The law r certificate has k lirector, page 2 s		25. Was case referred to me	dical				_		26. Place of D	Death (Chec	1 L Yes	2	NOI IL	les ZEINO
<u>S</u>	ysicia s cert direct	To Be	examiner? 1 Yes 2 No		Hospital:	Inpatien	t 2 🗆 ER/Ou	utpatien	t 3 🗆 DOA	Other: 4 🗆	Nursing H	ome 5 Res	idence	6 Other	Specify) Hospice
of	ding Physician: h. After this certific funeral director,		27. Manner of Death	ending	28a. Date (Mor	of injury		Time of injury	28c.	Injury at work?		28d. Describe	how inju	ury occurred	. (
0	tendir eath. or: Af the fu	ifica	2 Accident Ir	vestigation Could not b					M	1 Yes 2	P. □ No	001	D44	and March on a	an Dunal Paula Mumbar
Division of Vital Records,	I or Att	Certificate:		etermined	28e, Place	e of Injury ling, etc. (- At home, fa (Spec <i>ify)</i>	arm, stre	eet, factory, o	ince		City or To			or Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Obs1: 0) 161	LI Franci	in aw On the he	ole of ove	mination and/	ar invoct	tigation in my	oninion deat	h occurred a	and due to the c at the time, date ace, and due to t	and blac	ce, and due to	the cause(s) and manner stated.
	o the	Σ	opry one) 3 Cert 29b. Signature and title of ce	_	se Practioner	: Io the be	est of my know	neage, c		icense numb		ice, and due to			Month, Day, Year)
	->-0		1			. M	ρ .		0	0071	28	7	\	2(8	10
TY			30. Name and address of pe	rson who			11 (11 00)	(Type, F	Print)	0		.11		N. N	
1	1			ale	rey.6	701	N.C.	100	les SI	r. Su	ite	4105	Ba	Hime	poeil an, 21204
	Sta Registi		31. Date filed (MoNth, Day, Y	010	32.	Hegistrar'	s Signature	New.	1						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Cindy **Yvette** Madison December 2010 pM 4a. Facility Name (if not institution, give street and number)
Gilchrist Hospice 4b. City, Town, or Location of Death **Towson** 4c. County of Death Baltimore Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 □ M 2 🏿 F 222-42-7045 Days 09/07/1956 54 NJ Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3215 Lily Avenue 21227 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? 1 Never Married 2 X Married If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Registered Nurse Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Shirley Harri John Berry Harris 19a. Informant's Name/Relationship (Type, Print) Lee Madison / Husband 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zio Code) 3215 Lily Avenue, Baltimore, MD 21227 Lee Madison / 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Final Journey Crem. 1 Burial 2XX cremation 3 Removal from State 12/13/2010 Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Peneral Service Licensee Dorota Marshall 21203

Pnysician/ Medical **Examiner**

Physician/

Medical

Director

Funeral

þ

Completed

Be

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-trans Division of Vital Records. P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Metal Canal Canal Canal Due to (or as a consequence of):	Approximate Interval Between Onset and Death
aminer	Sequentially list conditions, if any, bading to immunicate cause. Enter Underlying Cause (Disease or iinjury that initiated events	b. — Due to for as a consequence off:	
dical Ex	resulting in death) Last	Due to (or as a consequence of): I d	
Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year
Completed by P	Part II. Other significant conditions o	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? Yes 2 □ No 3 □ Probably 4 □ Unknown
Comple			24a. Was an autopsy findings available prior to completion of cause of death? 1
Be	25. Was case referred to medical examiner?	26. Place of Death (Check Hospital:	only one)
2	1 Yes 2 No	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Hor	ne 5 Residence 6 Other (Specify)
ficate	27. Manner of Death 1	(Month, Day, Year) Injury work? M 1 \(\text{Yes} \) 2 \(\text{No} \) No	8d. Describe how injury occurred
Medical Certificate:	4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street and Number or Rural Route Number, City or Town, State)
Medica	(Check 2 Medical Exam	sician: To the best of my knowledge, death occured at the time, date and place, and iner: On the basis of examination and/or investigation, in my opinion, death occurred at se Practioner: To the best of my knowledge, death occurred at the time, date and place	he time, date and place, and due to the cause(s) and manner stated
_	20h Signature and title of portifier	Logo Liverno male	

2010

21204

Registrar

31. Date filed (Month, Day, Year)

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Hazel W. Mackey 0430 AM liember 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Grove Adventist Rockville monta omery . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F Months 91 200-09-9456 September 8, 1919 | Pennsylvania Yrs **Director** Usual Residence of Decedent 10b. County 10a. State with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Montgomery Rockville 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 101 Watkins Pond Blvd. Apt. 403 20850 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 other than Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Federal Government 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental + Mackey Earl Wilson Page 1 and 2 should be Jane W. Krall injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other traconce. Gail E. Miller/Daughter 19216 Munger Farm Road, Poolesville, Maryland 20837 20b. Place of Disposition (Name of Montgomery Crematorium, Inc. 20a. Method of Disposition December 11 20c. Location - City or Town, State 1 🗆 Burial 2 🔯 Cremation 3 🗆 Removal from State Inc. 2010 4 Donation 5 Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Fumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Licenses M01607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ espirator disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner na Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Duality for the in con se uenne offi Exami physician and the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗍 Ectopic pregnancy in the past 12 months?
1 Yes 2 Valo Pregnant at time of death 5 Other (specify) Month Day Year cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown/ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Bleedine 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No After this certificate 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury s after death. 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2nd Date signed (Month, Day, (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 1 only one) M. D. 065505 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

9901

2. Registrar's Signa

MD

4

Medical Cer Dr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 8 Physician/ Month Mikulan Paul Joseph 2010 December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death belair Health and Rehabilitation center Hartord Belair 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Pennsylvania **Funeral** 1**X** M 2 □ F Months Days Hours 169-10-8515 Director 10 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatlith and Mertal Hyglene. Important: If item 27 is marked of wher than "naturaly, or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Bel Air 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21014 912 Autumn View Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, rmed Forces? þ 1 Never Married 2 Married Specify.White Maryland 21215-0036 If Yes, Give Year or Dates.1941-45 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Foreman 12 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Mikulan Helen Weidner ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 912 Claudia Nimmo / Daughter Autumn View Ct. Bel Air, MD 21014 Baltimore, 20c. Location - City or Town, State West Chester, 20b. Place of Disposition (Name of 1 ☐ Burial 2 XCremation 3 ☐ Removal from State cemetery, crematory or other place Ferris & Co. 12/10/2010 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania ²² Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
333 S. Parke St, Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence on). Examin Due to (or as a consequence of): attending physician for use as the buria Physician/Medical that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day signed by the a d be detached t g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Parkinson's disease / dementa 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy perform hin 24 hours after death.

the Funeral Director. After this certificate I
repleted filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No ☐ Yes of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: 1 🗌 Yes မ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at -28d. Describe how injury occurred 1X Natural 5 Pending work Division 1 🗌 Yes 2 🗆 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination arrovor investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2.

To the Foundation of the Foundation o 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) /9 2010 D 0063981 MP. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benjamih Havre de Grace MD 37 Re MP Revolution

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

DEC

13

2010

32. Registrar's Signatu

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Joseph P. O'Beirne December 10, 2010 10:30PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6800 Guest Call Apt.237 Elkridge Howard 5. Social Security Number 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 □ F 134-14-4947 83 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items on the reaumating or other traumating o 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2▼ No Director Maryland Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6800 Guest Call Apt. 237 21075 USA Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 Q/ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1944 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: White 1946 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Sales Industrial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph O'Beirne Nora Corbett ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph M. O'Beirne / Son 5 Seyton Court, Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc | 12/13/2010 | Baltimore, Maryland 21. Signature of Funeral Service Licensee, Thomas Gregor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Conco /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Anknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? performe 1 □Yes 2 🗷 No 2 No 25. Was case referred to medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and P.O. Box 68760. Division of Vital Records,

1 Yes 2 No

5 Pending

1 Cannony Mille

investigation

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835

6 ☐ Could not be

27. Manner of Death

1 Natural

2 Accident 3 Suicide

4 Homicide

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

State Registrar

Medical Certification: To

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Smits Ave Smite 202

32. Registrar's Signature

28b. Time of

28c. Injury at Work?

Extrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Ballowe

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DA7683

1 ☐ Yes

2 □ No

28a. Date of Injury (Month, Day, Year)

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Pesidence 6 Other (Specify)

28d. Describe how injury occurred

12

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 13/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State o	of Maryla		artment of H tificate of D				ZUH.	39342
			Registrar 1. Decedent's Name (First, Middle,	Last)			incate of E	- Cutin	2. Date of De	Reg. No.		3. Time of Death
	Physicia Medic		Alice Marie	O¹M	elia				Month Decemb	Day Der 1	Year 3 . 201	0 3:40 AM M
, 4	Examin		4a. Facility Name (if not institution,				4b. City, Town, or	Location of Death			County of Dea	
			Gilchrist Cente	r for Ho	spice		Towson			Ва	ltimor	e
	Funeral		5. Social Security Number	5. Sex 1 □ M 2 X □ F	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 10/11	th y, Year)	9. Bi	rthplace (State or Foreign ountry) W York
	Director	H	094-26-5518 Usual Residence of Decedent	7.	76	Yrs.		l	10/11/	/1934	Ne	w York
	and show	è	10a. State 10b. County		10c. 0	City, Town or Loc	cation					10d. Inside City Limits
	Maryla 8a-f	ect	Marvland Harfor	ъ	Re.	l Air						1 🗆 Yes 2 🛛 No
	a or 2 be no	Funeral Director	10e. Street and Number		1 20.		10f. Zip Code			10g. Citi	izen of What C	ountry?
	n with	nera	1325 Littlefiel	d Place			21015			U. S	S. A.	
	deati riten inerr		11. Marital Status	Armed Fo	edent Ever in l prces?		Vas Decedent of Hi f Yes, specify Cuba				14. Race - Ame Black, Whi	
50	after al", o xam	a b	1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv	/e	1	☐ Yes 2 🎇 No	Specify:			Specify:	
ğ	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Completed by	15. Decedent			16a. Deced	lent's Usual Occupa	ation		16b. Ki	M. nd of Business	hite s Industry
21215-0036	in 72 e. nan "r	틹	(Specify only highes Elementary/Seconday (0-12)	t grade completed, College (1			kind of work done o O NOT use retired)	luring most of wor	king			
7	withi ygien yer th			5+		School	ol Teache					County Schoo
ğ	e filec ntai H ed otl	To Be	17. Father's Name (First, Middle, La	•				18. Mother's Nan	ne (First, Middle,	Maiden S	Surname)	
ž	uld but Mer market natic	-	John A. O'Melia						<u>Ferrata</u>			
Σ	2 sho lith an 27 is r r traur		19a. Informant's Name/Relationshi		- \		ng Address (Street &			-		
<u>စ</u> ်	nd B B E B	1	Barbara Tower (20a. Method of Disposition	Personal		. Place of Dispo	Mary Hil sition (Name of	1 Court	Bel All		ary Land ecation - City o	
ᅙ	ermit. Page 1 a er artment of H mportant: If ite ny injury or oth		1 ☐ Burial 2 🗶 Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 Removal from	n State	cemetery, cren	natory or other plac	1 14/	14		•	
Baltimore, Maryland	ermit. P er artm mportar ny injur nr e,	1	21. Signature of Funeral Service Lie			22	Crematory . Name and Addres	ss of Facility				Maryland
ň			Mechail	C. 200	throw	5r. B1	ruzdzinsk 407 Old E	i Funera astern A	l Home] venue]	PA Essex	. Mary	land 21221
			23a. Part 1. Enter the disease, or o shock, or heart failure. List or	omplications that	caused the de	eath. Do not ente	er the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
14	Mysician/	6	Immediate Cause (Final disease or condition	me	tasto	itic C	vorion	Cano	es			O s t and Death
	Medical Examiner		resulting in death)	Due to	(or as a conse	equence of):						
	- LAGITIMI C	<u>_</u>	Sequentially list conditions,	b. —								
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to	(or as a conse	equence ot):						
D .	xecut	Exa	that initiated events resulting in death) Last	c. Due to	(or as a conse	equence of):						
9	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical		d								
_	ificate ig phy as the		IF FEMALE.						-			
89 x	n cert tendir r use	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, ou	tcome of preg Birth 2 🗆 Fe	nancy etal death 3 [Ectopic pregnanc	:y			23d. Date of de	
Box	death the attended for u	Completed by Physician/M	1 Yes 2 No	4 ☐ Preg 9 ☐ Unk	nant at time o	of death 5	Other (specify)				Month	Day Year
Ö	The law requires that the ate has been signed by the page 2 should be detach	Ph/	Part II. Other significant condition	s contributing to a	death but not r	resulting in the u	nderlying cause giv	en in Part I.	23e Did t	obacco II	se contribute t	to the cause of death?
ν, σ.	res th signe	d b					,g g					Probably 4 Unknown
ğ	requi been should	ete			-				24a. Was	an	24b. Were a	utopsy findings available
မိုင	e has	ᇤ							auto perfe	psy ormed/	prior to death?	completion of cause of
<u>~</u>	an: Th tifficat or, pa		25. Was case referred to medical	-(1			26. Pla	ace of Death (Che	1 Yes	2 X No	1 L Ye	es 2 No
Ž	ysicia is cer direct	To B	examiner?	Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3 🗆 DOA Othe	er: 4 Nursing H	lome 5 🗆 Resi	dence 6	ther (Spe	city HODOICE
ō	ng Ph ter th neral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date	of injury oth, Day, Year)	28b. Time of injury	28c. Injury work	/ at	28d. Describe			
0	tendir leath. or: Af the fu	ifica	2 Accident Investig	ation			M 1 🗆	Yes 2 □ No				
Division of Vital Records,	or At after d Direct in by	Certificate:	4 Homicide determine	28e. Place	e of Injury - At ing, etc. <i>(</i> Spec		eet, factory, office		28f. Location (City or To			ural Route Number,
	spital ours a eral [29a. Certifier 1 Certifying	Physician: To the h	nest of my kno	wledge death o	occured at the time	date and place a	nd due to the ca	ause(s) an	d manner as s	tated
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 to ompleted filled in by the funeral director, page 2.	Medical	(Check 2 Medical Ex	aminer: On the ba	sis of examinat	tion and/or inves		on, death occurred	at the time, date	and place,	, and due to the	cause(s) and manner stated.
	To th withir To th comp	-	29b. Signature and title of certifier	1 4	10 n.		29c. License		Ī		te signed (Mon	
					(fl	M	K136	1526		Dec	emb	er 13 2010
	8		30. Name and address of person w	ho completed cau	se of death (Ite	em 23a) (Type, F	Print)	20105 (I.	PIL TY	N . M	~ m	7 22011
	-0:		31. Date filed (Month) Day Year)	200	Registrar's £ign	natura	, Uil	TTCCII	U+ 1	<i>X</i>	1) "	2 449
	Sta Registra	e ar	31. Date filed (Month, Day, Year) DEC 1 4 201	Denny	J.	maturgarke						
									-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death De combe Day D. IDAM Physician/ Dorothy Orem Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ari Ame Baltimore Washington Medical Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5 Social Security Number Age (In yrs. last birthday) Funeral Hours Min. 95 220-30-5031 Director Oct.4. 1915 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location 10a. State with the Maryland Director Examiner must be notified 1 Yes 2X No Baltimore Halethorpe 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 6 21227 United States 200 1st Avenue items 23a Funeral death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. ō 1 Never Married 2 Married 1 Yes 2 XNo ð 3altimore, Maryland 21215-0036 72 hours after White 1 ☐ Yes 2 🛣 No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working other than Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. Book keeper Construction 12 n/a injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed. Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic event ည Nellie Clement Mynard Lake 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1027 Upton Road Glen Burnie, MD 21060 Mary Butz / Daughter 20b. Place of Disposition (Name of Meadowridge)
Meadowridge
Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Dec. 11, 2010 Elkridge, MD 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road Lansdowne, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events resulting in death) Last g physician and is the burial-trans Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ģ 5 Other (specify) Pregnant at time of death the Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 DXNo 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed page 2 should peen 24b Were autopsy findings available 24a. Was an has autopsy performe 1 Yes 2 No certificate Yes 2 No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director. In the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 2 No 1 Dehpatient 2 ER/Outpatient 3 DOA □ Nursing Home 5 □ Residence 6 □ Other (Specify) ္ပင 28a. Date of injury (Month, Day, Year) 27. Magner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Registrar

Jennifer S	Shankle	Owen
------------	---------	------

Please Type or Print in Black Indelible	Ink. Ensure All Copies Are Leg	jible.	
State of Maryland / Department	of Health and Mental Hygiene	2010	39344
0 - 1:5 - 1 -	. C D 11.	terms for 8 had	

		1- For State Registrar	,	Certifi	icate of D	eath		,R	eg. No.	000044
Physicia Medical Examir		Decedent's Name (First, Midd						2. Date of Dea Month	Day Year	3. Time of Death 0256 hrs
Medical Examin	içi	4a. Facility Name (if not institution	Jennifer Ston, give street and number			City, Town, o	or Location of Dear	Decembe	4c. County of Death	
		70 Westbound at Rou	ute 85, East Street		F	rederick			Frederick	
Funeral		5. Social Security Number		ge (In yrs. last t		f Under 1 Ye			rth (MM/DD/YYYY) 9. Bir Foreig	ın
Director		216-60-1621	1 M 2 KF	49	Yrs.		, , , , , , , , , , , , , , , , , , ,		er 15, 1961 co	untry) New York
any	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Location					10d. Inside City Limits
	٦	Maryland Mo	ontgomery			ח	amascus			1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number	oner y		10	Of. Zip Code	amadead	1	0g. Citizen of What Cou	ntry?
th the 23a or			Haney Avenu				20872			States
11215-0036 Id be filed within 72 hours after death with the Maryland Aental Hygiene. arked other than "natural", or items 23a or 28a-f aboverent, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 X M	12. Was Deceder	\$?			lispanic Origin? (s an, Mexican, Puert		o- 14. Race - Amer White, etc.	ican Indian, Black,
fter de		3 Widowed 4 Div	vorced If Yes, Give Year	2X No	1 Ye	s 2X N	o s <i>pecify:</i>		Specify:	White
nours a	ed by	15. Decedent's Education (Spe					ation (Give kind of fe. DO NOT use re		16b. Kind of Business/	
36 in 72 han "1	Completed	Elementary/Secondary (0-12)		r 5+)						-
21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	통	17. Father's Name (First, Middle	, Last)		<u>L</u>	egal S	ecretary 18 Mother's Nam	ne (First, Middle, I	Le Maiden Surname)	gal
215 be file ntal H rked	Be	Dani 19a. Informant's Name/Relations	el R. Shanki	Le, Jr.				Nancy	y Anthony	
D 21 should and Me	유					-		Rural Route Nun	mber, City or Town, State	- 12
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	-	Paul E. Ow 20a. Method of Disposition	en/ Husband	20b. Plac	26619 e of Disposition	Haney (Name of c	Avenue.	Damascı Date	us Marylan 20c. Location - City or	d 20872 Town, State
Baltimore, bernit. Pages 1 ar Department of Hec Important: If ite		1 X Burial 2 Cremation	_	orom	aton, or other	nlace)		ecember		
altin mit. P. partme portan	ŀ	4 Donation 5 Other S 21. Signature of Funeral Service		l of	Heaven 22. Nam	Cemet e and Addre	ery 1. ss of Facility Ro	bert_A.	Pumphrey F	ng, Maryland uneral Home/
E B B B		X(e)	Seafet	M00335	Ro Ro	ckvil] ckvil]	e, Inc. e, Maryl	300 West and 208	t Montgomer 50-2805	ng, Maryland uneral Home/ y Avenue
Physician	10	23a. Part I. Enter the disease, or failure. List only one cause	on each line,		not enter the n	node of dying	g, such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Inj∪rie Due to (or as a con							Death
· cw		Sequentially list conditions,	b							
	jë	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a con	sequence of):						
lisit ed	Examiner	events resulting in death) Last	Due to (or as a con	sequence of):						
0, e be executed rsician and burial - transit	Medical	UNPENDED	dAMENDED							
Box 68760, ideath certificate be he attending physic difor use as the burned.	Med	IF FEMALE:	23c. If yes, outcome	ome of pregnand	СУ				23d. Date of delivery	,
Sox 687 leath certifit e attending for use as t	cian	past 12 months?	I CIAG DILAI	at time of death	2 Fetal of	leath 3 (Specify)	Ectopic pregn	ancy	Month , [Day Year
BOX e death the atte	Physician	1 Yes 2 No 9 V Unl	known 9 Unknown		J Other	(Specify)	····			
P.O. es that the igned by to detache	by P	Part II. Other significant condit	tions contributing to dea	th but not result	ing in the unde	erlying cause	given in Part I.		obacco use contribute to s 2 ✓ No 3 Prot	
duires t	Ed							24a. Was		topsy findings available
cords, law requir	Completed			_				autop perfoi	prior to or med?	completion of cause of
tal Recian: The certificate ector, page		25. Was case referred to medica	1			26 Plan	ce of Death (Check	1 Yes	2 No 1 Y	es 2 No
Vital Rec hysician: The this certificate	m̃,	examiner? 1 ✓ Yes 2 No	Atamital:	ient 2 ER/	Outpatient 3		Other		Residence 6 🗸 Other	Scene
Division of Vital Records, tal or Attending Physician: The law require rs after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be	2	27. Manner of Death	28a. Date of In (Month, Day Dec 8, 2010		o. Time of Injury		ury at Work?		how injury occurred	n
Sion Vittend death. cctor:	gi	Natural 5 Pend 2 Accident Invest	stigation		41 hrs	-	Yes 2 ✓ No			
Division pital or Attentours after death ceral Director:	Certification:	dete	ld not be	Injury - At home, ajor Road / I		actory, office	building, etc.	or Town, S	Street and Number or Ru State) d at Route 85, East S	- 11.
hou hou		4 Homicide 29a. Certifier 1 Certifying Pl	hysician: To the best of			at the time,	date and place, an	<u> </u>		
To the How within 24 h	Medical	one) 2 Medical Exa	miner: On the basis of ex and manner stated		r investigation,			at the time, date		
	Σ	29b. Signature and title of certifie					.M.E.		29d. Date signed (Mos December 8, 201	
10	-	30. Name and address of person	who completed cause of	death (Item 222)	0.0			December 6, 20	···
10			sistant Medical Exa		•	et, Baltin	nore, MD 2120	01		
Sta Registi	-00	31. Date filed (Month Pay Year)	10 32. Registr	ar's Signature	ares					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 8 40 AM Wesley K. Paul 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN Square Hospital Rosedale Baltimore 5. Social Security Number If Under 8. Date of Birth (Month, Day,) 6. Sex 7. Age (In vrs. last birthdav) 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Funeral 1**x** M 2 □ F Months Hours 608-50-2949 Director 54 Malaysia Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo Baltimore Essex MD 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? than "natural", or items 23a Funeral 934 MAce Avenue 21221 Malaysia 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Completed by 2 No within 72 hours after 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Malay 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Manager Retail 4yrs Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Hepzibah Devanesam ပ Daniel Paul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 934 Mace Avenue Baltimore MD 21221 Kathleen P. Paul /wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burjal; 2 🔯 Cremation 3 🗆 Removal from State Bayview Crematory Baltimore MD 4 Denetion 5 Other (Specify) 10/10 21. Signature Funda Service Lice 22. Name and Address of Facility 300 Mace Ave. Baltimore MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Infacction Myocardial disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): and -transit Hospital or Attending Physician; The law requires that the death certificate be executed Tobacco Abuse Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Day Year 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital. Other: 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Contriving Nurse Prantioner; T. the best of my knowledge, death persuad at the time, date and place, and due to the case(s) and manner as stated 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

Wosle

4000

FRANKLIN Square

Baltomd 21237

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

CourTRE

4 2010

31. Date filed (Month, Day, Year)

DEC

McCluskey

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Year P_{M} December 12, Albina Mary Peterson 1:48 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
July 19, 1923 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 X F Hours 216-16-6210 87 Baltimore, Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Glen Arm 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10824 Factory Road 21057 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Aberdeen Proving Ground Payroll Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Louisa Colette Sabitino Volpini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10830 Factory Road, Glen Arm, MD 21057 Thomas Peterson/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 1 Burial 2 Cremation 3 Removal from State Parkwood Cemetery 17, 2010 Parkville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 23a. Hart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, thock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disase or conum sulting in death) ase or condition a Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause E for Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami and -transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-1 Physician/Medical Records, P.O. Box 68760 nding p. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 🔀 Natural 5 Pending 2 No 1 Tyes Accident Director: A Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) hin 24 hours at the Funeral D upleted filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of Q 29c. License number 29d. Date signed (Month, Day, Year) 71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year CLAUDE PEACOCK 2010 153 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death timore 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 1 M 2 🗆 F Months Min Director 561 important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10d. Inside City Limits Director 1 🗆 Yes 2 🖾 No 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in O.S. Armed Forces? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 Yes 2 No Specify Specify: Blac 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than DO NOT use retired) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle 18: Macher's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - Pity or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Greene Funetal Services 23a. Part 1. Ent y the lisease, or co. plications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest shock, or his art ailure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Metastastic breast Cappinoma 400 Medical Due to (or as a consequence of) Examiner Anomia Sequentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): attending physician and for use as the burial-transi thromhocychena Hospital or Attending Physician: The law requires that the death certificate be executed mounty that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical 5428 fix pentonsian Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has i autopsy performed? Yes 2 N After this certificate 2 No 25. Was case referred to medical examiner? Be (funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 \square Pending work? Accident
Suicide 2 No Investigation after death Director; / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 at the time, date and place, and due to the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0100. 12-12-2010 D30494

DHMH 17 Rev 7/2009

I(i)

State

Registrar

Baltimore

NV

21218

Maiden choice lane

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KDETAIMO

31. Date filed (Month, Day, Year)

DEC

14

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 39348 State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $^{\text{Day}}2$. 2010 KATHLEEN LOUISE **GELINAS** December 12:00 PM POLK Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 402 Woodlawn Road Baltimore N/A8. Date of Birth (Month, Day, Year) 1945 if Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏋 F Days Hours New York 128-36-7667 Director Yrs 65 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "---- any injury or other than the marked other than "----10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland N/A Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 402 Woodlawn Road 21210 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Deceuent 2√0. Armed Forces? 1 ☐ Yes 2 📈 No Black, White, etc. 1 Never Married 2 Married ğ If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 Divorced Specify: Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
T. Rowe Price (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Investment Services Vice President Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Lester Curran Gelinas Margaret McCabe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Oakdale Road, Baltimore, Maryland 21210 Sarah Polk, M.D. (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 \square Burial 2 XCremation 3 \square Removal from State 4 Donation 5 Other (Specify) Green Mount Crematory 12/14/2010 Baltimore, 21. Signal us of Funcial Service Like a

Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL 6500 York Road, Baltimore, HOME INC Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. interval Between Onset and Death Immediate Cause (Final Physician 10 castual disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Year ☐ Pregnant at time of death ☐ Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pertensi Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

Yes 2 No Director: After this certificate I 1 ☐ Yes 2 ☐ No 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 Tyes Other 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, weath occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IGLEHART

DHMH 17 Rev 7/2009

State Registrar

IREDELL W.

31. Date filed (Month, Day, Year)

6301 N Charles St., Ste 5, Baltimore, MD 21212

III,

M.D.,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

hilip Picarello	St 1- For State Registrar	ate of Marylan	d / Departm <i>Certific</i>			Mental F		201 eg. No.	0 39349
Physician Medical Examine	Decedent's Name (First, Middle)			-			2. Date of Dea Month	Day Year	3. Time of Death 1418 hrs
Todioui Examino	4a. Facility Name (if not institution	 Picarello n, give street and numb 	per)	4	b. City, Town, or L	ocation of Deat	Decembe	4c. County of D	
·	3939 Roland Avenue			_	Baltimore			N/A	
Funeral Director	5. Social Security Number 219–44–9021	6. Sex 7. 1XM 2F	Age (In yrs. last bii	thday) Yrs.	If Under 1 Year Months Days	If Under 24Hr Hours Mir	_	Birthplace (State or	
any	Usual Residence of Decedent 10a. State 10b. County		10c. City, Towr	or Location	on				10d. Inside City Limits
	Maryland N/A		Balt	imore					1XXX Yes 2 No
with the Maryland as 23a or 28a-f sho	10e. Street and Number 3939 Roland Aven	ue Apt 714			10f. Zip Code 212	211	1	0g. Citizen of What USA	Country?
215-0036 be filed within 72 hours after death with the Maryland and Hyggene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Ma 3 X Widowed 4 Div	12. Was Deced Armed Force 1 Yes orced If Yes, Give Year		If Ye	Decedent of Hispa s, specify Cuban, I	Mexican, Puerto		White, e	merican Indian, Black, ic. White
urs afte tural" tunine	3 X Widowed 4 Div	or Dates:	completed) 16a.		Yes 2XX No s Usual Occupatio		work done	Specify: 16b. Kind of Busin	
5 72 hou in "nail al Exu	Elementary/Secondary (0-12)	College (1-4			st of working life. [OO NOT use ref	ired)		,
5-0036 led within 72 hour: Hygiene. other than "natu the Medical Exan	6 17. Father's Name (First, Middle,	1 0		Root			(E) 4 2 C L H 2	Union	Work
	Robert Chandl	er	Lac	A - 181		Audrey	Robinsor		
MD 21 2 should th and Me 27 is ma To	Melvin Chandler	Brother	118		-			nber, City or Town, S Maryland 21	
# # # # # # # # # # # # # # # # # # #	20a. Method of Disposition				ion (Name of ceme		Date	20c. Location - Cit	
MOI Pages tent of nut: If	1 Burial 2 XXX Cremation 4 Donation 5 Other St	_	Atlant	ic Cre	enatory	12	/16/2010	Glen Burni	e, Maryland
Baltimore, permit. Pages I as Department of He Important: If ite	21. Signature of Funeral Service		1)	²² Bui 363	me and Address of BI Falls Ro	Seitz Fur ad, Balt	neral Home imore, Mar	e, Inc. 212 yland	11
Physician	23a. Part I. Enter the disease, or failure. List only one cause	complications that caus on each line.	sed the death. Do n	ot enter the	e mode of dying, su	uch as cardiac	or respiratory arro	est, shock, or heart	Approximate Interval Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerot		ılar Dise	ase				Death
•	Sequentially list conditions	b.	insequence or).						
iner	if any, leading to immediate	Due to (or as a co	nsequence of):						
0, 0, e be executed sician and burial - transit	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of):						
30, te be executed sysician and burial - transit	UNPENDED	AMENDED							
on of Vital Records, P.O. Box 68760 anding Physician: The law requires that the death certificate lath. rr. After this certificate has been signed by the attending phys he funeral director, page 2 should be detached for use as the bution: To Be Completed by Physician/Me		1 Live birth	t at time of death	2 Feta	al death 3 er (Specify)	Ectopic pregna	ancy	23d. Date of del Month	ivery Day Year
o.O. Be that the de detached for Phy	Part II. Other significant conditi	9 Unknow	n eath but not resultin	g in the ur	derlying cause giv	en in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
ires that the signed by be detacled by F.O.	Prior Stroke						1 Yes	2 No 3	Probably 4 VI Unknown
Division of Vital Records, P.(ial or Attending Physician: The law requires tha is after death. ial Director: After this certificate has been signed led in by the funeral director, page 2 should be det ertification: To Be Completed by			, ,,					sy prior med? deat	
tal Reco					26.Place o	f Death (Check		2 No 1	Yes 2 No
F Vital Physician: r this certif	1 Yes 2 No			utpatient	<u> </u>			Residence 6 🗸 C	ther: Scene
on of anding Ph. th. r: After to funeral in	27. Manner of Death 1 Natural 5 Pend	28a. Date of (Month, Date)	Injury 28b. ay,Year)	Time of In	, , , , , ,	at Work? s 2 No	28d. Describe h	now injury occurred	
vision Atto free de Directo in by t	2 Accident Inves 3 Suicide 6 Could 4 Homicide	tigation 28e, Place of 28e (Specify)	f Injury - At home, f	arm, street	, factory, office bui	lding, etc.	28f. Location (\$ or Town, \$		r Rural Route Number, City
Div To the Hospital or within 24 hours aft To the Funeral Di completely filled in	29a. Ceriller .	ysician: To the best on the basis of each manner state	xamination and/or						
F S F S	29b. Signature and title of certifie				29c. License			29d. Date signed	
	111		Mar		O.C.M	.E.		December 9,	2010
5	30. Name and address of person Russell Alexander MD	•	of death (Item 23a) dical Examiner	111	Penn Street, B	Baltimore, M	D 21201		
State		32. Regis	strar's Signature						

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Narcisa M. Pearsall Month Day Year 11: 50A M December 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Season's Hospice Baltimore Randallstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 212-94-1121 Months 71 Country)
Philipines Director Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD 1 XYes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 1009 Kevin Road 21229 USA 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Philipino If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filer of Health and Mental F item 27 is marked of r other traumatic ever ည Lorenzo Leona Silverio Marcos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and .
Department of Health
Important if Item 27
any injury or other tra James Persall / Spouse 1009 Kevin Road, Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other page 1) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Final Journey Crem. 12/14/2010 Woodbine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland cremation Services
PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End-Stage Renal Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🖾 No Day signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a Was an has autonsy death? Yes 2 1 Yes 2 No within 24 hours after death,

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NSRiyapashieM.D 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N - S Regapall Se / M · D · 2835 Sm · In Av · 5 - 203 -

Registrar DHMH 17 Rev 7/2009

State

N.S. Kajapallse, M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Baltimore, MD. 21209

10-09476	C	Please Type or Print in Black Indelible Ink. Ensure Al Evara State of Maryland / Department of Health and M	II Copies Are	e Legib	le.,	10351	
Allison Romero-		1- For State Certificate of Death		Reg. No			
Physicia Medical Exami		Decedent's Name (First, Middle,Last) Allison Romero-Guevara	Mont	of Death Day ember 9, 2	Year 2010	3. Time of Death 1512 hrs	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Locat St. Agnes Hospital Baltimore	4b. City, Town, or Location of Death 4c. County of Baltimore				
Funeral Director		Months I Days I H	Under 24Hrs. 8. Date	7235	//DD/YYYY) 9. B		
		Usual Residence of Decedent		May 28,	2010	ountry) MD	
daryland 28a-f shrw any 1 at once.	ō	10a. State 10b. County 10c. City, Town or Location Wil	ndsor Mill			10d. Inside City Limits 1 Yes 2 No	
death with the Maryland or items 23a nr 28a-f shn must be notified at once.	Director	10e. Street and Number 7117 Rolling Bend Rd.	21244	10g. Ci	tizen of What Co	untry? J.S.A.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Impurtant: If item 27 is marked wher than "natural", or items 23a nr 28a-f shin injury or other traumatic event, the Medical Examiner must be notified at once.	/ Funeral	11. Marital Status 1 Never Married 2 Married 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1. Yes 2 No	kican, Puerto Rican, e	or No-	14. Race - Ame White, etc.	erican Indian, Black,	
6 n 72 hours a an "natural cal Examin	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) infar	NOT use retired)	16b.	Kind of Business	/Industry nfant	
115-003 filed within al Hygiene. ed nther th	Be Comp	17. Father's Name (First, Middle, Last) Edwin Romero 18.Mo	other's Name (First, M		n Surname) n Guevara		
AD 212 2 should be h and Ments 27 is mark matic even	ToB	19a. Informant's Name/Relationship (Type, Print) Wilson Romero Uncle 19b. Mailing Address (Street and I 2803 Gresham Way					
imore, N Pages I and nent of Healti ant: If item or other trau		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery crematory or other place) New Cathedral Cemetery 4 Donation 5 Other Specify:	Dec 14, 2		Location - City o	r Town, State Dre, Maryland	
		THE THE PART OF TH	lumbia Pike Elli				
Physician /Medical /xaminer		23a. Part. Enter the ase, or complications the caused the death. Do not enter the mode of dying, such a failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Asphyxia Due to (or as a consequence of):	as cardiac or respirate	ory arrest, sr	оск, ог пеап	Approximate Interval Between Onset and Death	
	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Wedging Due to (or as a consequence of):					
11/2 =	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
executed an and all - transit	_ 1	d. x UNPENDED □ AMENDED 23a,b,27,28a-f per me g	915 5-4-11	vt			
Division of Vital Records, P.O. Box 68760, rat or Attending Physician: The law requires that the death certificate be exert after death. 1 Director: After this certificate has been signed by the attending physician a led in by the funeral director, page 2 should be detached for use as the burial -		IF FEMALE: 23c. If yes, outcome of pregnancy	topic pregnancy	23	3d. Date of delive Month	ry Day Year	
s, P.O. I ires that the signed by the detacher	<u>a</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in		-		the cause of death?	
Division of Vital Records, P.O. Box 68 To the Bospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed		[Was an autopsy performed? Yes 2	prior to death?	utopsy findings available completion of cause of	
ictor, p	å	examiner? Hospital: A Company of the	eath (Check only one)	5 Posid			
n of V ding Phys After thi funeral d	۵: ای	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at W	Vork? 28d. Des	cribe how inj	jury occurred	d between	
Division of Vital to the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif ompletely filled in by the funeral director.	Certification:	Natural 5 Pending Investigation 2 X Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building	g, etc. 28f. Loca	and c	rib and Number or R	ural Route Number, City	
Hospital of 24 hours al Funeral E		4 Homicide determined (Specify) residence	Apt.	A B	altimore		
To the E within 2- To the F	edical	(Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.					

State Registrar

Russell Alexander MD. 31. Date filed (Month, Day, Year)

REC 1 4 2010

30 Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Assistant Medical Examiner 32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

December 10, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep	partment of Health and Nertificate of Death	Mental Hygier	2010 39352
	Physicia		1. Decedent's Name (First, Middle, Last) LOUIS J. REICHART IZ		2. Date of Death Month	Day Year 3. Time of Death
}	Medic Examin		4a. Facility Name (if not institution, give street and number) Good Samaritan Hospital	4b. City, Town, or Location of Death Baltimore City		4c. County of Death Baltimore City
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Yea, Dec. 15,	9. Birthplace (State or Foreign
	Director	L	213-28-1626	ocation	Dec.15,	
	Marylan 28a-f sh otified a	Director	,	more City		10d. Inside City Limits 1XXYes 2 □ No
	with the 23a or	Funeral D	10e. Street and Number 4119 Hamilton Avenue	10f. Zip Code 21206	10g.	Citizen of What Country? USA
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importants if time Z7 is marked other than "natural", or items Z3a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2 No If Yes, Givek orean Year or Dates.	Was Decedent of Hispanic Origin? (Spi If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Baltimore, Maryland 21215-0036	within 72 houn giene. er than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) lder	ing	aco. Inc.
and	be filed ental Hyg ked oth c event,	To Be	17. Father's Name (First, Middle, Last) Louis Joseph Reichart, Sr.	18. Mother's Nam	e (First, Middle, Maide	,
Mary	should h and Me 7 is mar raumati		19a. Informant's Name/Relationship (Type, Print)	ing Address (Street and Number or Rura 9 Hamilton Avenue	al Route Number, City	or Town, State, Zip Code)
more,	Page 1 and 2 ent of Healt nt: If item 2 ry or other		20a. Method of Disposition 20b. Place of Disposition XX Rurial 2 Cremation 3 Removal from State cemetery, cre		Date 20c.	Location - City or Town, State
Baltii	permit. F Departm Importa any injur		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Lassahn Funeral how 7401 Belair Rd. Ba	ne	
-	Physician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition HYPOXIC RE		or respiratory arrest,	Approximate Interval Between
	Examiner	je.	Due to (or as a consequence of):	PNUMCHIF	7	18 HRS
8	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): LAPARO TOMY	FOR CHRONIC	DUODENA	AL >7 DAYS
09	e be exe ysician a ie burial-i	dical E	resulting in death) Last Due to (or as a consequence of): d.		OBSTR	LUCTION
Division of Vital Records, P.O. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral after death. To the Funeral after this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
О.	es that th igned by be detac		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death?
ords	w require s been s 2 shoufd	Completed by			24a. Was an	2 No 3 Probably 4 Unknown 24b. Were autopsy findings available
l Rec	n: The la ficate ha n; page 2		25. Was case referred to medical	00 51 (5 -1) (01	autopsy performed	
Vita	hysicia his certi	To Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatie			6 ☐ Other (Specify)
o uo	er ding F seth. or After t he funera	Certificate:	27. Manner of Death 1 1 1 1 Natural 5 □ Pending 2 □ Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time of injury (Month, Day, Year)	of 28c. Injury at work? M 1 □ Yes 2 □ No	28d. Describe how inj	jury occurred
Divisi	al or Atters all or Atters all or Directo		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)
_	he Hospita in 24 houra he Funera ipleted fille	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred a	t the time, date and pla	ace, and due to the cause(s) and manner stated.
	Not Not Con		29b. Signature and title of certifier MEDICINE RESIDENT	29c. License number RESOOO		Date signed (Month, Day, Year) 12 0 9 2010
\	140,		30. Name and address of person who completed cause of death (Item 23a) (Type,	AMARITAN MOSE	BALT.	IMURE, MD
	Stat Registra	e	31. Date filed (Month, Day, Year) DEC 14 2010 Survey S. Mark	J		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible amend #19a Per FH G910 12/14/10 JH/ #1perPHYS, G910, 12/29/2010, WS State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) **Marian Elizabeth** 2. Date of Death 3. Time of Death Marian Physician/ Month 12 2010 Marion Elizabeth Roth 6:50 AMM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🛛 F Hours 01/05/1916 Director 94 212-05-1777 Marvland or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Harford Fallston 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1705 Parkvue Road 21047 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) f Health and Mental Hygiene. item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Clerk Police Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ <u> William J. Greelev</u> Elizabeth M. Reis 19a. Informant's Name/Relationship (Type, Print) (Personal Rep) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Gardner (Presenal Rep 7206 Belair Road - Baltimore, Maryland 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Cem.12/17/2010 Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 67 Tas 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician ementia disease or condition reeur Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to for selection excuse of signed by the attending physician and abe detached for use as the burial-transi Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? 1 Yes 2 WNo Director: After this certificate 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\sum \) YNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number D0070635 12/13/16 MUD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ù Pate 6701 N Charles Suite 4105 Bultimenp MD ZIZEL

Registrar

31. Date filed (Month, Day, Year)

82. Registrar's Signature

				se Type or Pri							•	э.	
		-		State of Mem 26 per v	erb.,	g910	ertificate of L	Odhb Death			2010	39354	
	Physicia Medic		110010 [2: 121131013212							2. Date of Death Month Day Year 12 44 AM			
	Examin	er	4a. Facility Name (if not institution, g	SPIN	5 PINTL 4b. City, Town, or Location of Dec			4c.		County of Death			
	Funeral Director		5. Social Security Number 217-09-5417 Usual Residence of Decedent 6. Sex 1 □ M 2 対 F 7. Ag			e (In yrs. last birthday) 94 If Under 1 Year Months Days Hours Min.			8. Date of Birth 9. 08-02-1916			sirthplace (State or Foreign Country) MD	
	led within 72 hours a Hygiene. other than "natural" ent, the Medical Ex	ctor	10a. State 10b. County			10c. City, Town or Location Baltimore						10d. Inside City Limits 1 ☐ Yes 2 🏝 No	
		al Dire	MD Baltimore 10e. Street and Number		10f. Zip Code			:	_	Country?			
		uner	26 Deer Run Court, Apt F 11. Marital Status 12. Was Decedent			21227 Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe			osifu Vac or No		ates		
9036		þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ 1 ☐ Yes 2 ☑ 1 ☐ Yes 2 ☑ 1 ☐ Yes Give Year or Dates.		? I No		If Yes, specify Cuba	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🙀 No Specify:		14. Race - Amer Black, White Specify:			
15-0		Completed	15. Decedent' (Specify only highest			(G	ecedent's Usual Occup ive kind of work done	during most of work	ing	16b. I	Kind of Busines	s Industry	
212			Elementary/Seconday (0-12) College (1-4 or 5			iffe. DO NOT use retired) Assembly Person				Um	Umbrella Manufacturing		
and		To Be	17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Mid Susie Dawk			,		
aryla			James Bowen 19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rura						Zip Code)	
Ž			Audrey M. Reifsnider - daughter 26 Deer Run Court, Apt F, Baltimore, MD 21227										
Baltimore, Maryland 21215-0036			20a. Method of Disposition 1										
Balti			21. Signature of Funeral Service Lic		11.0	$\overline{}$	22. Name and Addre	ss of Facility Gar	y L. Ka	aufm		eral Home at , MD 21075	
			23a. Part 1. Enter the disease, or coshock, or heart failure. List on	omplications that cause	d the deat	h. Do not	enter the mode of dyir	ng, such as cardiac o	or respiratory ar	rest.	IKITUBC	Approximate Interval Between	
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. AS/	PIRA	TO	- PNEC	Mana	, 7			Onset and Death	
	Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or iinjury			uence of):	SANTE	ry ()15EAS8	٤			
	ed sit	Examiner				a consequence of: AUTHOR PREUMANA, a consequence of: AUTHOR DISEASE a consequence of: Y PERTENSE							
	executed an and rial-transi	al Exa	that initiated events resulting in death) Last	c. Due to (or as									
200	cate be physicis the bu	edica	1	d									
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medic	IF FEMALE: 23b. Was decodent pregnant in the Dast 12 months? j □ Yes 2 □ No g □ Unknown	23c. If yes, outcome of pregnancy 1						23d. Date of delivery Month Day Year			
Z.0.		oy Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?				
rds,	equires een sig nould b	eted I	DENEWNA						-	Yes 2 No 3 Probably 4 Unknown			
	ne law re e has b age 2 sh	omple								psy ormed?	prior to death?		
A B	ian: Th	Be C	25. Was case referred to medical examiner?					lace of Death (Checi	1 ☐ Yes k only one)	2	lo 1 L Y	′es 2 □ No	
# 1	Physic r this ce ral dire	은	1 Yes 2 No								ecify) Asiasta		
ono	ending eath. or: Afte he fune	Certificate:	1 Natural 5 Pending 2 Accident Investiga	(Month, Da	Month, Day, Year) injury injury M 1 ☐ Yes 2 ☐ No								
$\# \mathcal{A}_{\mathcal{A}} / \mathcal{O} \in \mathcal{A}_{\mathcal{A}}$ Division of Vital Records, P.O	ital or Atturs after deral Directoried in by t		building, etc.			c. (Specify) City or Town, S.							
10	n 24 hou n 24 hou e Funei bleted fill	Medical	29a. Certifier (Check (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Met Jical Examiner: Do the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
	To the within to the company of the		29b. Signature and title of certifier	C.fh	In		W 29c. Licens	e number 0538		_	ate signed (Mor	nth, Day, Year)	
		er i	30. Name and address of person wi	no completed of use of	death (Item	1 23a) (Typ	e, 'Print)				-		
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registr			ale						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 9th 2010 Month 1945 OMENICK DECEMBER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death of Maryland Medi cal Conter Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Country) 1 X M 2 □ F Months Days Hours Min. Mar I, Day Year Director 117-44-9962 Italy Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Carroll Woodbine 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7431 Woodbine Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. \$ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: If Yes, Give White Specify: 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Basketball Science Teacher/ Education/Athletics Coach Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Nicodemo Romeo Vittoria Scalli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7431 Woodbine Road, Woodbine, MD 21797 Mrs. Lois K. Romeo (Spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) McKendree Cemetery 12/13/2010 West Friendship, MD 21. Signature of Funeral Service License 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, P.A. PO Box 195 Sykesville, MD 21784 Barg Staught Herbert 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Worsened Ischemic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 20 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) physician and the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ for end stuge kidney 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 Yes 2 🗹 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 922323492 Dec. 2010 Resident Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

DHMH 17 Rev 7/2009

Registrar

John

31. Date filed (Month, Day, Year)

22

Baltimore

St

Greene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month) e.c. Catherine Ε. Stratford 20 pm 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Belair Health and renabilitation center Air Harford Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😾 F Months Days Hours Min. (Month, Day, Y Pennsylvania 093-14-5189 Director 88 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Harford Bel Air 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? 23a Funeral 1704 Stone Ridge Court 21015 United States items ; 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married ō Completed by Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. If Yes, Give should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", Specify: 3 Widowed 4 Divorced Year or Dates White traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Office Clerk Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Wasnak Anna Hensel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Michael E. Stratford Son 1704 Stone Ridge Ct., Bel Air, Maryland 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Metro Crematory Inc. 12/13/201 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland 21. Signature of Funeral Service Licensee Alyson Taylor 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. on t enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Onget and Immediate Cause (Final et and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or imjury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 mon page 2 should be detached for Pregnant at time of death 1 Yes 2 9 Unknown the been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy After this certificate 2 N 1 🗌 Yes Jratford Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes Other 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 13 2010 30. Name address of person ath (Item 23a) (Type, Print) Busines 71090 308 31. Date filed (Month, Day, Year 32. Registrar's State Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician/ rrison Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore center N/A If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Funeral (Month, Day, Year) 1 XM 2 □ F Days Hours Min. 80 Yrs. Director 214-26-8742 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County Director 1 Yes 2 No Maryland Harford Edgewood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 1945 Chipper Drive 21040 USA Was Decedent Ever in U.S. Armed Forces? 1946
If Yes, Give 1948 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🌂 ☐ No Specify: Specify: White 1948 3X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72. h and Mental Hygiene.
7 is marked other than "r permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Supervisor Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ၉ Harold Stewart Sarah Unk. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1206 Apparition Lane Middle River, Maryland 21220 Deborah Lease, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12/10/10 Baltimore, Maryland Metro Crematory Inc. ^{22. Name and Address of Facility} Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Signature of Funeral Service Licensee Thomas Gregor Mmay 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Hemorrhaa Medical Due to (or as a consequence of Examiner Sequentially list conditions, Completed by Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death ☐ Pregnant at time of death ☐ 5 ☐ Other (specify) ____ 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Hospital or Attending Physician: The law require 24 hours after death.
 Funeral Director. After this certificate has been sing the factor of the funeral director, page 2 should in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes completed filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the within To the 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 4432 12, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Buite 1210 21201 Bea Greene 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 14 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Effie Strickland [g) 2010 5:52 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Baltimore Timonium 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗓 F Year 919 Days Hours July 21, Mary land 263-01-8510 91 Director Yrs Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Baltimore Timonium 1 ☐ Yes 2X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2300 Dulanev Vallev Road Unit W102 USA 21093 within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 5:52 р.ш. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: Completed 3X Widowed 4 □ Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) salth and Mental Hygiene. n 27 is marked other than er traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Food Industry Manager Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Arthur Noah Fleagle Emma Virginia Cuddy 19a. Informant's Name/Relationship (Type, Print) 6 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1501 National Road Rosedale, Maryland 21237 Susan Harding, Niece Department of Healt Important: If item 2 any injury or other once. ECEMBER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 10/13/10 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death STRICKLAND 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō Month 4 Pregnant Pregnant at time of death 5 Other (specify) Day Year signed by the page 2 should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? Yes 2 No 2 🗆 No 1 🗌 Yes 25. Was case referred to medical Division of Vital the funeral director, 26. Place of Death (Check only one) 2 X No Other: 1 Yes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After X Natural 5 Pending work' 1 Yes 2 No after death Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 A Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

JUNECIA WHITE,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

32. Regist ar's Signature

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ D)9 UCE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Pasadena 268 Arundel Road Anne Arundel Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 1 2 6 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min 219 42 5510 °1944 Director 66 MD Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10a. State Examiner must be notified at **Funeral Director** 10d. Inside City Limits MD Anne Arundel Pasadena 1 ☐ Yes 2 No ō 10e. Street and Numbe 10f. Zip Code 10q. Citizen of What Country? 23a 268 Arundel Road 21122 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any Injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗆 No 196
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1961 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced 1965 White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Welder Anne Arundel County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ralph L. Shipley Emma Grace Blizzard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce McAllister – daughter 268 Arundel Rd. Pasadena, MD 20a. Method of Disposition
1 □ Burial 2 X Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 Donation 5 Other (Specify) <u>Crematory 12/11/10</u> | Baltimore, 22. Name and Address of Facility GJ Gonce Funeral Signature of Eureral Service Licensee Home 169 Riviera Drive Pasadena, MD 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or illing) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 2 No Yes 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 👺 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the lirector, page 2 st autopsy perforn Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify s after death.
I Director: After this of in by the funeral d 27 Manner of Death 28a. Date of injury (Month, Day, Year, 28b. Time of 28c. Injury at Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident

Accident

Suicide

Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours af

To the Funeral D

completed filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title Date signed (Month, Day, Year) cause of death (Item 23a) MEL

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		T- State of Maryland / Dep	ertificate of Death	Vientai Hygier Reg. i	21111	39351
Physic		Dilord, and Dilord,		2. Date of Death Month Dec . 1	^{Day} 20 ^{Year} 0	3. Time of Death 6:54p M
Exan	dica nine		4b. City, Town, or Location of Death		4c. County of Death	
Funer Direct		5. Social Security Number 213-82-8134 6. Sex 1 □ M 2 🖾 F 7. Age (in yrs. last birthday) 45 Yrs.		8. Date of Birth (Month, Day, Year NOV 13	9. Births	place (State or Foreign
yland -f show ed at	, ide	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Leading MD Baltimore Essex				0d. Inside City Limits
ith the Mar 3a or 28a it be notifi	Emory Director	10e. Street and Number 1243 Punjab Drive	10f. Zip Code 2 1 2 2 1	10g.	Citizen of What Cour	1 Yes 2 XNo
YIBNG Z1Z13-UU36 Id be filed within 72 hours after death with the Maryland Mental Hygiene. narked other than "natural", or items 23a or 28a-f show atic event, the Medical Examiner must be notified at	7,4	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 No If Yes, Give	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	etc.
Z1Z13-UU36 within 72 hours after giene. er than "natural", o , the Medical Exam	Potol C	3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Dece	1 Yes 2 No Specify: edent's Usual Occupation skind of work done during most of work	in a 16b.	Specify: Whit	
ZIZIZ I within 72 ygiene. her than '			emaker		wn home	
Maryland should be filed and Mental Hy 7 is marked oth	T.			ne (First, Middle, Maide , Martin	en Surname)	
d 2 shoul alth and 27 is mer traums		1	ing Address (Street and Number or Run $65~Box~1485~Rom$		or Town, State, Zip C	Code)
Baltimore, Warylan permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition cemetery, cre Bayvie	matory or other place)		Location - City or To	
balt permit. Departi Import	ouce.	21. Signature of Funeral Service Licensee	2. Name and Address of Facility 30	00 Mace A		
- ^c h _a sicia		23a. Part 1. Enter the disease, or complications that caused the seath. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
Medic Examin	er	resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.				
cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
rou cate be executed physician and s the burial-transi	Podical E	resulting in death) Last Due to (or as a consequence of): d.				
DIVISION OF VITAL PECONGS, P.O. BOX 06/00 To the Hospital or Attending Physician: he law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, age 2 should be detached for use as the burial-transit	Physician/Med		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delive	ery Day Year
ires that the signed by Id be detailed	12	Tak in Salah digililisan salah salah gasa salah	underlying cause given in Part I.		use contribute to th	ne cause of death?
fecords, he law equires te has leen sig age 2 should b	Completed			24a. Was an autopsy performed?	prior to cor death?	osy findings available impletion of cause of
VICAL ysician: is certifical director,	To Be C	25. Was case referred to medical examiner?	26. Place of Death (Chec			
on or value of variation of the funeral of the funeral of the control of the funeral of the fune	Certificate: T	TE instituti 2 E en outpatio		28d. Describe how inj		
DIVISION ial or Attendii 's after death. al Director: Al ed in by the fu			reet, factory, office	28f. Location (Street a City or Town, Sta		Route Number,
he Hospit in 24 hour he Funera	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred a	t the time, date and pla	ce, and due to the cau	use(s) and manner stated.
To t with To t		29b. Signeture and title of certifier Auleanne Bethea enn	29c. License number MDR0653	29d. [Date signed (Month, L	Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type, 5200 EASTERN NE Part of	Print) WRE, MD	21224	1	
S Regis	tate strar	31. Date filed (Month, Day, Year) 92. Registrar's Signature	V			

		-	For State Registrar		Maryland		tment of I ificate of L			/giene	10	39362
	Physicia		1. Decedent's Name (First, Middle, John Rando]		D				2. Date of Do Month DECEMP	Day	Year 2010	3. Time of Death
	Medic Examin	er	4a. Facility Name (if not institution,	give street and numb	per)	Nore	BAL	Location of Deat	City	4c. County		NA
	Funeral Director		5. Social Security Number 215–22–4481 Usual Residence of Decedent	6. Sex 1 ☑ M 2 ☐ F	'. Age (In yrs. Ias		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		rth 12, 14, 1927	9. Birthpl Counti Balt	lace (State or Foreign ry) Maryland
	Maryland 28a-f show otified at	Funeral Director	10a. State 10b. County Maryland Balti	more	10c. City,	Town or Loca	tion Towson				10	0d. Inside City Limits
	vith the 23a or 3	ral D	10e. Street and Number 52 Theo Lane				10f. Zip Code	1204		10g. Citizen of V United	hat Count Sta	ry? Ces
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	à	11. Marital Status 1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Deced Armed Force ed 1 Yes, Give Year, or Date	es? 2 🔀 No			spanic Origin? (S n, Mexican, Puer	specify Yes or No- to Rican, etc.)	of Amer	e - America k, White, e whit	tc.
Maryland 21215-0036	ithin 72 hours ene. r than "natur the Medical I	Completed	15. Deceden (Specify only highes Elementary/Seconday (0-12)	t's Education		(Give kii life. DO	nt's Usual Occup nd of work done o NOT use retired) d Invest	during most of wo	rking	State of Health		
yland 21	d be filed w fental Hygi irked othe	To Be	17. Father's Name (First, Middle, La Randolph Milt					18. Mother's Na		, Maiden Surname ne Linder		er
, Mary	nd 2 should saith and N n 27 is ma er trauma		19a. Informant's Name/Relationshi Mrs. Margaret S		9		Address (Street a			er, City or Town, Sand 21204		ode)
Baltimore, N	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Bunal 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S _i		tate Eval	nce of Disposi metery, creme OS Func OC1 – Be	ion (Name of tory ozother place eral El Air	e) Dece 13,	mber 2010	20c. Location -		vn, State , Maryland
	permit. Depart Import any inj		21. Signature of Funeral Service of	Censee		Pea	lame and Address	s of Facility Lternative	s Funeral &		n Cer	nter, P.A.
-	Physician/		23a. Part 1 Enter the disease, or o shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on each	used the death. In line.		the mode of dying	g, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or	as a conseque		Lipusi	2				-
> -	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or	as a conseque	nce of):						
90	be e siciar buri	cal	resulting in death) Last	Due to (or	r as a conseque	nce of):						
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate E within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the total states.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outco 1 Live Bi 4 Pregna 9 Unkno	ant at time of de	cy death 3 🗌 i	Ectopic pregnanc Other (specify)	у		23d. Dat Mor	e of deliver	y Day Year
ls, P.O.	uires that the signed by all the detail		Part II. Other significant condition	_				en in Part I.		obacco use contri Yes 2 No		e cause of death?
Record	The law req ate has bee bage 2 shor	Completed by								psy pormed? d	lere autops rior to com eath?	sy findings available pletion of cause of
ital	certifica rector, p	Be	25. Was case referred to medical examiner?	Hospital:	/		Othe	ace of Death (Che	ck only one)			
Division of Vital Records,	ending Physath. or: After this he funeral di	Certificate; To	27. Manner of Death 1 D Natural 5 Pending 2 Accident Investiga	28a. Date of (Month,	patient 2 E injury 2 Day, Year)	R/Outpatient 8b. Time of injury	3 □ DOA 28c. Injury work	4 Nursing F		dence 6 Othe		
Divisi	ital or Attures after de ral Directo	al Certi	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ned 28e. Place of building	f Injury - At hom , etc. <i>(Specify)</i>				City or Tov			
	the Hospi hin 24 hou the Funer upleted fill	Medical	(Check 2 Medical Exonly one) 3 Certifying I	Physician: To the bes aminer: On the basis Nurse Practioner: To	of examination a	and/or investig	ation, in my opinio	n, death occurred	at the time, date a	and place, and due	to the caus	e(s) and manner state
	or with		29b. Signature and title of certifier	R. Pric	E		29c. License	690Z	.)	29d. Date signed DELEMBY		
17			30. Name and address of person w	F. Pricke	MD	SINH	T Hos	PITAL.	of BH	LT.more	Z	
	Stat Registra	~	31. Date filed (Month, Day, Year) NFC 1 4 2010	August 32. Reg	istrar's Signatur	ales		,				

ORIGINAL

			For State Registrar	State of Maryla		rtment of H			iene eg. No.	10	39363
	-		1. Decedent's Name (First, Middle, Last)					2. Date of Deat	h		3. Time of Death
	Physicia Medic		ALBERT Wayn	e	SC	HAEFER	Jr.	DECEMBE	R 141 2	20 ľ® r	10:45 A _M
	Examin		4a. Facility Name (if not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. Cour	nty of Death	
- 1			FOREST HILL HEALTH		ITATION	FOREST			HAI	RFORD	
	Funeral		5. Social Security Number 6. Sex	7	s. last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign
	Director		215 32 2491 1 L	x ^{M 2 □ F} 75	Yrs.			August 19	1935	_ Balti	more Co., Md.
	nd how at	<u> </u>	10a. State 10b. County	10c. (City, Town or Loc	ation				1	Od. Inside City Limits
	aryla a-f s ified	ect	Maryland Harford	Jar	rrettsvill	e					1 ☐ Yes 2 🛣 No
	or 28	١	10e. Street and Number		210000122	10f. Zip Code		1	Oa. Citizen	of What Cour	ntry?
	with t	era	3523 N. Furnace Road			21084			USA		,
	eath cems	Funeral Director	11. Marital Status	12. Was Decedent Ever in L	U.S. 13. W	as Decedent of His	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No-	14. B	lace - Americ	can Indian.
o	ter de , or it	by	1 Never Married 2 🗶 Married	Armed Forces? 1 Yes 2 No If Yes, Give				Rican, etc.)	В	Black, White,	etc.
$\frac{3}{2}$	ural"		3 🗆 Widowed 4 🗆 Divorced	Year or Dates. WW I	I I	Yes 2 X No	Specify:		Spec	ify: Wh	ite
21215-0036	2 hor "nat	Completed	15. Decedent's Edu (Specify only highest grad			ent's Usual Occupa	ation uring most of work	ina I	16b. Kind of	f Business In	dustry
7	thin 7	ĕ	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DC	NOT use retired)	Ť	i	D3 L 0	. D I	
Z	d with the rut, the rut, the	Be	11 17. Father's Name (First, Middle, Last)	N/A	100T &	Dye Maker	40.44.11.1.41			Decker	`
ä	ntal h	일	Albert Wayne Schaefer	Sn			18. Mother's Nam	e (First, Middle, N J. Hermina		ıme)	
Maryland	d Me d Me mark mativ	1 0	19a. Informant's Name/Relationship (Typ		461 14 7					01.4.77	
Σ	ge 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If frem Z is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Gladys M Schaefer (Wi		3523 N	V. Fumace	nd Number or Rura Road Jarre	ettsville,	Md. 21	1, State, ZIP (.084	Jode)
ā,	l and f Hea item other		20a. Method of Disposition	20b	. Place of Dispos	ition (Name of	!	Date	20c. Locatio	on - City or To	own. State
P	ent o ent o nt: If y or		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, cremetery, cremeter, cremetery, cremeter, creme	atory or other place emetery Dec	embe r 15 20			re, Mary	·
saitimore,	permit. Page 1: Department of I Important: If it any injury or of		21. ig at re of Funeral Service Acense								
ñ	permit Depar Impor any in	y s	Martin 2000	som (C)	La	assahn Fune 101 Relair	s of Facility Eral Home I Road Balti	nore Marv	land 21	236	1
			23a. Part 1. Enter the disease, or compl								Approximate
	Tiysician		shock, or heart failure. List only one Immediate Cause (Final	cause on each line.							Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. Due to (or as a conse	equence of).					-	
	Examiner										
	_	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence of):						
8	uted nd ransit	cam	Cause (Disease or imjury that initiated events	o						1	
	e exection and an animal-t	dical Examiner	resulting in death) Last	Due to (or as a conse	equence of):						
2	ate be hysic the bu			i							
20	intifica ling p e as 1	/Me	IF FEMALE:	On House subserve of none							
×	tth ce	ian	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1 ☐ Live Birth 2 ☐ Fe	etal death 3 🗌		у		1	Date of deliv Month	ery Day Year
gox	e dea the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time o 9 ☐ Unknown	ordeatn 5∟	Other (specify)				WICHT	Day Iou
7. Ö	nat th ed by detac	/ Ph	Part II. Other significant conditions cor	ntributing to death but not r	resulting in the ur	derlying cause giv	en in Part I.	23e. Did tob	acco use co	ontribute to t	he cause of death?
Š,	sign d be	d by	a July					1 🗆 Ye	es 2 🗆 No	o 3 🗆 Pro	bably 4\tag Unknown
Records,	requ beer shou	lete	, v					24a. Was ar	24	b. Were auto	psy findings available
ပ္	e has	Completed						autops perforr	y ned?	prior to co death?	mpletion of cause of
<u>r</u>	in: Th ificat or, pa	a)	25. Was case referred to medical			26 Pls	ace of Death (Checi	1 Yes	2 LNo	1 \sum Yes	2 LINO
<u> </u>	/sicia s cert direct	To B	examiner? 1 Yes 2 No	lospital: 1	☐ FR/Outpatient	Otho	er:	ome 5 Reside	6 T C	Whor (Coosife	d
0	g Phy er this neral o		27. Manner of Death	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury	at	28d. Describe ho			
0	andin sath. ir: Aft	fical	1 Natural 5 Pending 2 Accident Investigation		Injury	M 1 🗆	Yes 2 No				1
Division of Vital	r Atte ter de recto	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec		et, factory, office		28f. Location (Str City or Town		nber or Rura	Route Number,
É	italo irsafralDirsafiledir			, , , , , ,				Oity of Town	, Oraco,		
	Hosp 4 hou Fune ted fil	Medical	29a. Certifier 1 Certifying Physi- (Check 2 Medical Examin	cian: To the best of my kno er: On the basis of examinat	owledge, death or tion and/or investi	ccured at the time, gation, in my opinio	date and place, an	id due to the caus	se(s) and ma	nner as state	ed. use(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Ψ	only one) 3 Certifying Nurse 29b. Signature and title of certifier	Practioner: To the best of	my knowledge, de	eath occurred at the	e time, date and place	ce, and due to the	cause(s) and	manner as st	ated.
	5.≱ ₽8					29c. License				ned (Month, .	
	,		30. Name and address of person who co	malatad assess of death #1	em 00e) 77	D33	2257		Jecen	52/B	,2010
	141			615 W. MACP		·	AIR MD 2	1014			
	Stat	e	DR. DAVID DUNN - 31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature NO	ל חקת עה	XIK TID Z	1014			
	Registra		31. Date filed (Month, Day, Year) DEC 1 4 2010	Devent B.	gare	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAURICE SHORT DECEMBER 2011 14:45 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE LOCH RAVEN COMMUNITY LIVING CENTER If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F (Month Pay Year) 49 Mary land Director 212-56-3920 Usual Residence of Decedent Show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2422 N. Calvert Street 21218 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 X Never Married 2 Married 2 No δ X Yes altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Specify: 3 Divorced 4 Divorced Black and Mental Hygiene.
s marked other than "natural numatic event, the Medical Ex Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Builder Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Willie Scott Leverne Crowner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Strawbridge Terrace, Perry Hall, MD 21128 Mary Sheron Legette / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1
Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 12/13/2010 Hanover, Maryland Anatomy Gifts Registry 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. Ρ, MD Hanover, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ LUNG CARCINOMA disease or condition resulting in death) METASTATIC Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine of any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 2 No Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 M No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) melly 30272

State Registrar

9

DHMH 17 Rev 7/2009

3900 LOCAL PAVEN BOULEVARD, BACTIMORE,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS SMILLEN.
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #20b Per FH G911 1/12/2011 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Month Physician DECEMBER 6,2010 /Medical 4a. Facility Name (If not institution, give street and number) #Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeb. | 16, 4c. County of Death 4b. City. Town, or Location of Death **Examiner** NORTHWES CENTER BALTIMERE 9. Birthplace (State or Foreign Country) Maryland Age (In yrs. last birthday) **Funeral** Year) 63 1947 Director 212-52-9637 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Glyndon 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2 Central Ave. 21071 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1968-72 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☒ No Specify ₽ Specify. 3XXWidowed 4 □ Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important; if Item 27 is marked other the any Injury or other trements. 11 Waiter Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Norman W. Smith, Anna Pear1 Bates ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cathy J. White / Niece Glyer Ct., Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Uniformed Sers. Univ. 12/10/1010 4 ☑ Donation 5 ☐ Other (Specify) Bethesda, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility
Rapp Funeral and Cremation Services lex Human 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): executed Due to (or as a consequence of): Box 68760 attending physician Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) 1 ☐Yes 2 ☐ No Division of Vital Records, P.O. 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð CRITICALIVE PUNCONARY DILITASE WITO 1 Lives 2 No 3 Probably 4 Unknown Be Completed TA here 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ATRIAL FIBAILIATION RAPID VONTRIGICAR RATE 2 . Ne 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐Yes 2 ☐ No 2 Accident investigation 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19502 RANDALISTEN MANYLOS 21137 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

Controp

32. Registrar's Signature

B

OR CANDO 31. Date filed (Mooth, Day, Year)

			Please	Type or Print in Bla					
			For	State of Maryland /			ental Hyg	iene 2010	39366
			State Registrar		Certificate of D	eath		leg. No.	
	Physicia Medic	n/	1. Decedent's Name (First, Middle, Las Ronald	M. Schne	eider		2. Date of Deat Month Decemb	Day Year	3. Time of Death 0831 A _M
me d	Examin		4a. Facility Name (if not institution, give Howard Count	1 11	tal Colu	Location of Death		4c. County of Death How	
	Funeral Director		5. Social Security Number 6. Security 1 6. Security 1 6. Security 1 6. Security 1 7 6. Security 1 6. Security 1 7 6. Security	ex M M 2 □ F 7. Age (In yrs. last bi 56	rthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 05/31		hplace (State or Foreign intry) MD
	show dat	l. h	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	wn or Location			-	10d. Inside City Limits
	Mary 28a-f otifie	Director	unkn.	unkn.				unkn.	1 Yes 2 No
	th the 3a or t be r	la [10e. Street and Number		10f. Zip Code			10g. Citizen of What Co	·
	ath wi	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	nkn. 13. Was Decedent of His	spanic Origin? (Spec	nkn. cify Yes or No-	14. Race - Amer	
920	be filed within 72 hours after death with the Maryland antal Hygiene. Ked other than "natural", or items 23a or 28a-f show the other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces? ***X*Yes 2 \sum No Air If Yes, Give Year or Dates. Force	If Yes, specify Cuban	n, Mexican, Puerto F	Rican, etc.)	Black, White Specify: Wh	e, etc.
2-0	hours'natur	Set	15. Decedent's E (Specify only highest gra		a. Decedent's Usual Occupa (Give kind of work done du	ution wring most of working	na	16b. Kind of Business	Industry
21215-0036	led within 72 Hygiene. other than " ent, the Mee	Completed by	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DO NOT use retired) Salesm		·s	Finance	s
land 2	filed v al Hyg d othe	To Be	17. Father's Name (First, Middle, Last) Mannie Schne	ider		18. Mother's Name	(First, Middle, M	Maiden Surname)	unkn.
	2 shouth and the and t		19a. Informant's Name/Relationship (7 Emily Schneider		9b. Mailing Address (Street and 302 Jervis				
Baltimore,	permit. Page 1 and Department of Heal Important: If item any injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia	Removal from Statecemei	of Disposition (Name of tery, crematory or other place 1 Journey C	e) i	14/10	20c. Location - City or Woodbin	
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service Licens	Dorota Marsha	Maryl	and Cre	mation	Services	21203
		Г	23a. Part 1. Enter the disease, or comshock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.	not enter the mode of dying	, such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician/ Medical Examiner		disease or condition resulting in death)	a. Atheroscle Due to (or as a consequence		onary v	ascula	ir disease	
	Examine	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence	e of):				
28	executed an and irial-transit	Examine	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c	e of):				
09	rte be ex hysician he buria	dical		d					
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No g □ Unknown	23c. If yes, outcome of pregnancy 1		у		23d. Date of de Month	livery Day Year
P.O.	that the	y P	Part II. Other significant conditions of		g in the underlying cause giv	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
S,	quires en sign uld be	edt	Hyper-	tension o, demia		-	1 🗹	res 2□No 3□P	robably 4 🗆 Unknown
ecor	he law rec te has bee age 2 sho	omplet	Dyslig	o, demia			24a. Was a autop perfor 1 Yes	prior to death?	topsy findings available completion of cause of
a	ian: T rtiffica stor, p	Be C	25. Was case referred to medical examiner?			ace of Death (Check			
ξ	hysic his ce Il direc	은	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/		4 L Nursing Ho		lence 6 Other (Spec	ify)
υof	ling P .r After t funera	ate	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	(Month, Day, Year)	o. Time of 28c. Injury work M 1		28d. Describe h	ow injury occurred	
Division of Vital Records,	or Attend after death Director;	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not to 4 Homicide determined	De Place of Injury - At home			28f. Location (S City or Tow	itreet and Number or Ru n, State)	ral Route Number,
	e Hospita 24 hours e Funeral	Medical	(Check 2 Medical Exam	rsician: To the best of my knowledge niner: On the basis of examination and se Practioner: To the best of my kno	d/or investigation, in my opinio	n, death occurred at	the time, date ar	nd place, and due to the	cause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier	/ 0	aga Liconso	numbor		20d Data signed (Mont	h Day Vear
			M	17 x mo	Da	05331	2	December	, 7 2010
_	2+1		30. Name and address of person who Michelle Hengseld	completed cause of death (Item 23a	dar lane i C	olumbia	, MD	21044	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	parke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sinan Soc 11:54aM December 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washingotn Adventis Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Cambodia 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 04/20/1948 578-02-1965 1 🗆 M 2 🕮 F Min. 62 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Adelphi Prince George 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10008 Green Forest Drive 20783 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Asian Specify. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Interpreter Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Soum Soum Sonn Sipan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Teague / Spouse 10008 Green Forest Drive, Adelphi, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Final Journey Crem. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 12/11/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD Signature of Funeral Service Licensee Donota Marshall andre ! Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hysician HEPATO CELLULAL CARCINOMA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner HEPATITIS Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Dav Year 1 ☐ Yes ∠.e 9 ☐ Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, page Yes 2 No 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred **X** Natural 5 Pending 1 Tes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D54486 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAKOMA PARK, FLOSPITAL. WASHINGTON ADVENTIST HUYANH TON 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Emily Hope Salmo		S 1- For State Registrar	State of Marylar		rtment o		nd Men	tal Hy		g. No. 20	10 3936	
Physiciar Medical Examin	n/	Decedent's Name (First, Mid	Emily	Норе	e Sal	.mon		2	2. Date of Death Month December	n Dav Year	3. Time of Death 0545 hrs	
		4a. Facility Name (if not institut 13218 Brookdale Dri		ber)		4b. City, Town, of Hagerstow		of Death		4c. County of Washing		
Funeral Director		5. Social Security Number unkn		Age (In yrs. Ia	ast birthday) Yı	If Under 1 Ye Months Da		er 24Hrs. Min.		/1964	9. Birthplace (State or Foreign Country) MA	_
nd show any see-	Ī	Usual Residence of Decedent 10a. State 10b. County MD Was	hington	10c. City,	Town or Loca		agers	stow	n		10d. Inside City Limit 1 Yes 2 X N	
ith the Maryland 23a or 28a-f sho notified at occe	Director	10e. Street and Number	Partridge	e Trai	il	10f. Zip Code	21742	2	10	g. Citizen of Wha	at Country?	_
fter death w	by Fune	3 Widowed 4 D	Married 12. Was Deced Armed Ford 1 Yes divorced If Yes, Giva Year or Dates:	ces? 2 X No	1	as Decedent of H Yes, specify Cuba	n, Mexican, o specify:	, Puerto R	tican, etc.)	White, Specify:	White	
2 - =	Completed	15. Decedent's Education (Sp Elementary/Secondary (0-12 1 2				nt's Usual Occup nost of working lif Journ	e. DO NOT	use retire		16b. Kind of Bus	nalism	
21215-0036 Juld be filed within 7 Mental Hygiene. Levent, the Medica	8	17. Father's Name (First, Middle Warren S 19a. Informant's Name/Relation	almon		10h Mailir	18.Mother's Name (First, Middle, Maiden Surname) Pauline Ruskin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Star				State Zin Code		
MD 2 nd 2 should alth and M m 27 is m aumatic	Ĺ	Suzi Salmo			248	Centra	l St.	, A	cton,	MA 017	20	
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and I Important: If item 27 is to		20a. Method of Disposition 1 Burial 2 Crematic 4 Donation 5 Other S	Specify:	State Fi	nal Jo	urney Cr	em.	12/1	Date 6/2010	Woodbir	City or Town, State	
		21. Signalure of Funeral Servio 23a. Part I. Enter the disease, o		a Marsh		Name and Addres			ematic Balt	n Serv	ices _MD_21203	
Physician Medicul Examiner	1	failure. List only one caus Immediate Cause (Final diseas or condition resulting in death)	se on each line. se a. Complic	ations	Of Me						t Approximate Interva Between Onset and Death	
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b									
Tred ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C.	onsequence of	·):							
be executed sician and unial - transit	dical	X UNPENDED		3a,27	per me	g913 3-	1-11	vt				
Box 68760, e death certificate be the attending physic of for use as the burner.		IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 ✔ Ur	4 Pregnar	h It at time of dea	2 _ F	etal death 3 ther (Specify)	Ectopic	: pregnand	су	23d. Date of d Month	elivery Day Year	
P.O.		Part II. Other significant cond	litions contributing to d	eath but not re	esulting in the	underlying cause	given in Pa	rt I.			ute to the cause of death? Probably 4 Unknown	_
Records The law requestate has been page 2 should	Completed by								24a. Was a autops perform	y pri ned? de	ere autopsy findings available or to completion of cause of ath? Yes 2 No	e
Vital hysician:	8	25. Was case referred to medic examiner?	(Harpital:	atient 2	ER/Outpatier		e of Death (Residence 6	Other: Scene	
The state of the s							d	Ī				
<u></u>	1 X Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Roor Town, State) Could not be determined Could not							or Rural Route Number, City				
To the Hos within 24 h To the Fut	ल		Physician: To the best of aminer:On the basis of and manner stat	examination ar								ļ
	ž	29b. Signature and title of certif)			se number .M.E.			29d. Date signed December 9	(Month, Day, Year) , 2010	
OKON		30. Name and address of perso Melissa Brassell, MD		_ ` .	,	Penn Street, I	Baltimore	e, MD 2	1201			
Stat Registra	te ar	31. Date filed (Month, Day, Year	310 2 32. Regi	strar's Signatu	bark	,						

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:45 P M Alwin Charles Schneider, III 2010 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Glen Burnie 401 Glenwood Ave 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 6. Sex 1 M 2 □ F 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 8/30/1939 Director Yrs 220-36-5167 Usual Residence of Deceden 28a-f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at **Funeral Director** 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No MDAnne Arundel Glen Burnie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 401 Glenwood Ave 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 XYes If Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: 3 ₩ Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Financial Manager Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Alwin C. Schneider, Jr. Dorothy Priebe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bradley Scheider/ Son 7516 Hollybrook Rd., Glen Bunrie, MD 21061 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 4 Donation 5 Other (Specify) Atlantic Crematory 12/6/2010 Glen Burnie 21. Signature Juneral Service Licer 22. Name and Address of Facility Ambrose Funeral Home Inc 1328 Sulphur Spring Rd., Arbutus, MD 21227 a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Interval Between Onset and Death Immediate Cause (Final Ph sician/ ALCOITO IRRH disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death s after death. Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 🗌 Yes 2 🗌 No filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 🗆 Cepitying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title o D0040017 who completed cause of death (Item 23a) (Type, Print)

N. MO 405 FREDRICH REND SUITE 2041 (ATENSUIUE, MO 21828 s of person MO rooyon

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Stevens 7:30 PM Dec. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Annapolis Anne Arundel Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year ct. 15 1 X M 2 - F Director 219-76-1641 61 1949 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1600 Forest 21403 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces \$ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: "natural", 3 XWidowed 4 ☐ Divorced Specify: White Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pete Stevens Helen Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie Pizo-Daughter 1600 Forest Drive, Annapolis Maryland 21403 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Western Cemetery Dec.15.2010 Baltimore Maryland 21. Signatur of Funeral S e Licen 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road Lansdowne MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final et and Death Physician/ disease or condition Medical resulting in death) **Examiner** 01 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No funeral director, 26. Place of Death (Check only one) 2 No Hospital Other: 은 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer (Month, Day, Year) 1 Naturai 5 Pending iniury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title o completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Stickney 2010 11:15 A M December Carol Α. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Bethesda Suburban Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral Days Hours July 21, 1930 1 □ M 2 🗓 F New Jersey Yrs. Director 152-26-6368 80 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10h. County 10c, City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 No North Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 United States 5550 Tuckerman Lane 12. Was Decedent Ever in U.S. Armed Forces2. 1 ☐ Yes 2 ⚠ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Federal Government Be Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Dorothy Ann Marshall t. Page 1 and 2 should be thent of Health and Mentant: If item 27 is marke Dewey James Waters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1810 Valley Terrace, S.E., Washington, D.C. 20032-4629 Karen Beth Johnson/Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1:
Department of I
Important: If it
any injury or of December 15 cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Bethesda, Maryland Montgomery Crematorium, Inc. 21. Signature of Funeral Service Dicenses Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. the Holm 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Sepsis Medical resulting in death) Due to (or as a consequence of): Examiner Hypernatremia Sequentially list conditions, if any, leading to immediate cause. Enter Underhing Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) Urosepsis Due to (or as a consequence of) resulting in death) Last Physician/Medical Dehydration IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No Dav Year Pregnant at time of death Unknown 9 Unknown Hospital or Attending Physician; The law requires that the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by History of Stroke 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has performed? Yes 2 No 1 🗆 Yes 2 🗆 No ☐ Yes Division of Vital Be (25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🗓 No Hospital Other: မြ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred X Natural 5 Pendina Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral D 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29h. Signature and title of certifier 29c. License number SUDARSHAN 165312 address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20814 Sava Sudarshan, M.D. 31. Date filed (Month, Day, Year) Registrar's Signa State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2

		-	For State	State of Maryla	-	artment of Hea rtificate of Dea		lental Hygi	ene	
			Registrar 1. Decedent's Name (First, Middle, Las	st)	Cei	tilicate of Dea	alli	2. Date of Death	g. No. 2010	3. Time of Death
	Physicia Medic	al	ADOLPH	SELIG	MK			Ponth	9 Zulo	740 DM
	Examin	er	4a. Facility Name (if not institution, give SEASONS HOSPICE		пось	4b. City, Town, or Loc RANDALLS			4c. County of Death BALTIM	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.		If Under 1 Year If	Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Director			XIM 2 □ F 91	Yrs.	Months Days H	lours Min.	01/08/1	919 Coul	WV WV
	nd how at	<u> </u>	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	taryla 3a-f s tified	Director	MD N/	A	1	BALTIMORE				1X Yes 2 □ No
	the Na or 29	Ö	10e. Street and Number			10f. Zip Code		10	lg. Citizen of What Cou	intry?
	h with	Funeral	3825 LABYRINTH				1215		US	A
	r deat or iter	by Fu	11. Marital Status1 ☐ Never Married 2 X Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 🛣 No	.S. 13.	Was Decedent of Hispai If Yes, specify Cuban, M	nic Origin? (Spe lexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
980	safte ral", c Exan		3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2 🏌 No S	Specify:		Specify: WH	ITE
5-0	filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.	Completed	15. Decedent's E (Specify only highest gr			dent's Usual Occupation kind of work done durin		na 1	6b. Kind of Business In	ndustry
12	thin 7 ane. than he Me	Som	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. D	O NOT use retired)			*****	
d 2	filed wi al Hygie d other event, t	Be (17. Father's Name (First, Middle, Last)	<u>5+</u>		SALESMA 18.		e (First, Middle, Ma	HARDWA	RE
<u>lan</u>	ould be find Mental marked matic ev	1	HARRY	SELIGMAN			IDA		SHOR	
Maryland 21215-0036	2 should be the and Me 27 is mark		19a. Informant's Name/Relationship (T		. 1	ng Address (Street and				
	and Hea em the		NAOMI SELIGMAN 20a. Method of Disposition			5 LABYRINTH			E, MD 2121	
Baltimore,	Page 1 nent of I ant; If it ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	cemetery, crei	natory or other place) CEMETERY			Oc. Location - City or T	
計	permit. Page 1 Department of Important: If ii any injury or o		21. Signature of Funeral Service Licens	T		2. Name and Address of		ACT IS A CONTRACT OF	BALTIMORE ON & BROS.	
<u> </u>	B Dec) Eins a		89	900 REISTER			ESVILLE, M	•
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	no cause on each line		A	_			Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. 41/0	ruso	le co h'	c (andra	MASCAL	Onset and Death
	Examiner		1	Due to (or as a consec	quence of):					
		iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Due to for as a conse.	Hence of):					
7	cuted ind transit	Examiner	Cause (Disease or linjury that initiated events	C						
-	cate be executed physician and the burial-transit	alE	resulting in death) Last	Due to (or as a consec	quence of);				:	
760		edical		d					-	
89	ath certifica attending p for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1 Live Birth 2 Fe	ancy	Ectopic pregnancy			23d. Date of deliv	very
Box	To the Hospital or Attending Physician: The law requires that the death certification within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of		Other (specify)			Month	Day Year
P.O.	at the		Part II. Other significant conditions c	ontributing to death but not re	sulting in the	underlying cause given i	in Part I.	23e. Did toba	acco use contribute to	the cause of death?
S,	ires the signer of the signer	d by						1 ☐ Yes	2 9 0 3 □ Pro	obably 4 🗆 Unknown
ord	w request speed	plete						24a. Was an		ppsy findings available
Records,	The lar ate ha page 2	Completed						autopsy perform 1 Yes 2	ed? death?	ompletion of cause of 2 No
ta	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			of Death (Check	7	1.1	
Division of Vital	Physic this card dir	<u>ان</u>	1 ☐ Yes 2 PNo 27. Manner of Death	1 Inpatient 2 28a. Date of injury	ER/Outpatie			me 5 Residen	-	300 4
on C	nding ath. r: Afte e fune	icate	1 Natural 5 ☐ Pending 2 Accident Investigation	(Month, Day, Year)	injury	work?	; 2 □ No	zod. Describe now	injury occurred	
/ISIC	r Atte ter der irector	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injury - At h		reet, factory, office		28f. Location (Stre	et and Number or Rura	al Route Number,
ó	pital o		00-0-0-0-0	D,						
	e Hos n 24 ho e Fun	Medical	(Check	sician: To the best of my know iner: On the basis of examinati se Practioner: To the best of r	on and/or inves	stigation, in my opinion, d	death occurred at	the time, date and	place, and due to the ca	ause(s) and manner stated.
	To th To th comp	<	29b. Signature and title of certifier	$\sim \sim$	1	29c. License nur			d. Date signed (Month,	Day, Year)
	_		· Cless	201h	1111	10/3	870	2	Dec 10	,2010
_	5		30. Name and address of person who	completed cause of death (Ite		Print) 34 Azi	madia	~B/v	. 6 3	76/
	Stat	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign		37-1V1	70,01	-10/0	(0 2)	40/
	Registra		DEC 1 4 2010	house d.	back	1				

			State of Maryland Den State Amend Items 3 per dr.,g910,12 Registrar	71472010 digith and M rtificate of Death	lental Hygier	e 0 1 0	39373
	Physici		1. Decedent's Name (First, Middle, Last) William Tauber		2. Date of Death	Day Year	3. Time of Death 5:50 a M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Funeral		Fairfield Nursing Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 5. 78 18 4.207 19 M 2 F 97 Yrs.	Crownsville If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea		place (State or Foreign intry)
	Director		578-18-4307	ocation	Dec 13, 1		nington DC 10d. Inside City Limits
	the Mary	Director	MD Anne Arundel Annap	001is	100.6	Citizen of What Cou	1 Yes 2 No
	with page	<u></u>	1978 Glencrest Lane	21401		USA	,
	ns 23	era	11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	
36	irs after o	by Funeral	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ▼ No Specify:	Rican, etc.)	Specify: wh:	
21215-0036	within 72 hours after death with the Maryland ene. then "raturel", or Items 23e or 28e-f show the Medical Exercinet must be notified at	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)		. Kind of Business/li	ndustry
2	ygien ygien yerth t, Ine	Con		nalyst		manage	ment
land	uld be fil Aental H rked oth tic even	To Be	17. Father's Name (First, Middle, Last) John Andrew Tauberschmidt		e (First, Middle, Maid nina Marga:		ks
Maryland	nd 2 shouth and N			ing Address <i>(Street and Number or Rur</i> Glencrest Lane Ar			p Code)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or Items 23a or 28a-1 show apprintury or other treumatic event, the Medical Examinat must be notified at Once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☑ Donation 5 ☐ Other (Specify)	osition (Name of matory or other place)	Date 20c.	Location - City or T	own, State
Balti	permit. Departm Importe eny inju			tate Anatomy Board	_	altimore	Street
8760,	death certificate be executed A granding physician and and ior use as the buriat-transit	ical Examiner	23a. Part i Enter the disease, of complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Pinal disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	ter the mode of dying, such as cardiac	or respiratory arrest, See (B)	oor) Bleed	Approximate Interval Between Onset and Death
.O. Box 68	death certifi e attending I d for use as	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of deli	very Day Year
<u>α</u>	The law requires that the ate has been signed by the page 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to	the cause of death?
Il Reco	The law re cate has bee page 2 sho	Completed by			24a. Was an autopsy performed 1 Yes 2 2	? death?	topsy findings available ompletion of cause of 2 No
of Vita	Physicien: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2	nt 3 DOA Other: 4 Nursing He	th (Check only one)		ify)
Division of Vital Records,	Attending I ir death. ector: After by the funer	Certification:	27. Manger of Death 1	Work? ' M 1 ☐ Yes 2 ☐ No	28d. Describe how in 28f. Location (Street City or Town, St	t and Number or Ru	ral Route Number,
	the Hospitel or hin 24 hours afte the Funerel Dir npletely filled in	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.				
)	To the P within 24 To the F complete	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type SYE) MAHBOB, MI)	Print) 2007 17 Suite 1-1	2 Anna	Ler C	My Their
	Sta Registi		31. Date filed (Month, Day, Year) DEC 1 4 2010 32. Registrar's Signatura Acceptable 1. Acceptable	Ked		1	,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:15 AM ame Medical Oty, Town, or Location of Death 4a. Facility Name (if not institution, give street and number 4c. County of Death Examiner HIMORR If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) last birthday **Funeral** (Sonthy Pay Hours Director Usual Res dence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Id be filed within 72 hours after death with the Maryland Mental Hygiene. Director 1 Yes 2 No more 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces?
Yes 2 \sum No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit: Department of Health and Mental Hygiei Important: If item 27 is marked other t Be Mother's Name (First, 17. Father's Name (First, Middle, Last) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signat A of Funeral S rice L censee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause n each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 2 No 1 \square Yes Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has page 2 perform 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) 2 XNo 1 🗌 Yes Certificate: To 1 Dispatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after death. I Director: After t injury 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Marse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the ly one within To the 29d. Date signed (Month, Day, Year)

3 State

State Registrar eted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Amend Item 26 per verb., g910, 12/14/2010dnb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Charles Thompson December 2010 5:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice - Dove House Carroll Westminster If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 X M 2 1 F 02/13/1957 Maryland 220-62-2755 53 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Carroll Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 or than "natural", or items 23a or the Medical Examiner must be Funeral within 72 hours after death with 21791 U.S.A. 912 Baust Church Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc. 1 Never Married 2 X Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 | Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event". (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Office Technician Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Arthur M. Thompson Susanna Manasco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 912 Baust Church Rd., Union Bridge, MD 21791 Martha V. Thompson / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1

Burial 2

Cremation 3

Removal from State 12/09/2010 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry Hanover, Maryland 21. Signature of Funeral Service Licer, 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease, or c shock, or heart failure. List only Onset and Death Immediate Cause (Final Priyeiclant rimary final disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for Examir that the death certificate be executed attending physician and I for use as the burial-transit Thrombocutesi. that initiated events resulting in death) Last Due to (or as a consequence o Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ed by the a Unknown P.O. s been signed by the should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Malnumition, Revere anemia 3 Probably 4 ☐ Unknown of Vital Records, 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform the Hospital or Attending Physician; The certificate 2 No 1 Yes Yes 2 Hospice 25. Was case referred to medical 26. Place of Death (Check only open Be examiner? 2 No Dove House Other: DOA ပ္ 6 Other (Specify) Nursing Home within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 5 Pending Division 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 912 Washington Rd Westminster, MD 21157 d address of person who con eted cause of death (Item 23a) (Type, Print) assandra aust

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 7, Physician/ David Teets 2010 9:45P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5552 Link Avenue Arbutus Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 - F Months July 16, 1940 West Virginia 70 Yrs 171-32-1981 **Director** Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at Director 28a-f MD Baltimore Arbutus 1 🗆 Yes 🚈 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21227 5552 Link Avenue United States Page 1 and 2 should be filed within 72 hours after death \nment Of Health and Mental Hyglene.
ant. If item 27 is marked other than "natural", or items ant. If you other traumatic event, the Medical Examiner mury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White Completed Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Truck Driver Commerce Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Prentice E. Teets Velma Maxine Sisler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce, Shirley M. Teets-Wife 5552 Link Avenue, Arbutus, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State urial 2 Cremation 3 Removal from State Atlantic Crematory Dec 11,201 Glen Burnie Maryland 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ioblastoma disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day Year signed by the a ld be detached fi 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2 No Yes 2 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Tyes ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Hospital or Attending Pl 24 hours after death. Funeral Director: After the Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pendina 1 Yes 2 No Accident Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

Registrar

DHMH 17 Rev 7/2009

State

29a. Certifier

(Check

only one) 29b. Signature an

3

30. Name and address of person

31. Date filed (Month, Day,

pleted cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

CATON

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

BALT MD

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 2010 10:55 AM SANDRA TOSSMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TATLER PLACE OWINGS MILLS 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 M 2 T Days Min. Months Hours 06/28/1947 Yrs Director 216-46-1377 63 Usual Residence of Decedent or 28a-f shov 10a. State 10d. Inside City Limits filed within 72 hours after death with the Maryland by Funeral Director 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No BALTIMORE OWINGS MILLS MD 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? 23a 3 TATLER PLACE 21117 USA or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed, 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) REGISTERED NURSE NURSING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important; If item 27 is marked o any injury or other traumatic eve 2 Page 1 and 2 should be DAVID **FALCK** ROSE FRIEDMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 TATLER PLACE, OWINGS MILLS, MD ALAN TOSSMAN/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Donation 5 Other (Specify) BALTIMORE HEBREW CEM: 12/12/2010 REISTERSTOWN, MD Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the reat Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MPHON Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 Day Month Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 1 🗆 Yes Certificate: To 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 1 Yes 2 No Investigation within 24 hours after deatl completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and the (Item 23a) (Type, Print) ause of deat Q 31. Date filed (Month, Day, Year) State 4 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav Year Hahn Upton Lois Dec. 10 2010 11:27 P^M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 8439 Lyndale Drive Pasadena Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 □ F Min. Director 213-22-0649 84 Dec. 09 1926 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examiner must be resulted as 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8439 Lyndale Drive by Funeral 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🔂 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. White 3 ☑ Widowed 4 ☐ Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Billing Clerk Utility Company 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Louis Hahn Elizabeth 2 Pumphrey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen V. Hahn-Walter 965 Point Pleasent Road, Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 15 20c. Location - City or Town, State Dec. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. 2010 Baltimore, Maryland 21. Signature of Funeral Service Liven 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest agus of each line. 23a. Part 1 Enter the disease, or complica shock or heart failure. List only one Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) nset and Death years Physician ement /Medical Due to (or as a consequence of) Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last month Examine Due to (or as a consequence of): Attending Physician: The law requires that the death certificate be executed and P.O. Box 68760, Due to (or as a consequence of): attending physician for use as the buria Physician/Medical yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Month Year 1 Yes 2 No 9 Unknown 5 ☐ Other (specify) the detached þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 3 Completed page 2 should 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 ☐ Yes 2 🙀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 5 X Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) in by the funeral 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred 1 X Natural 5 Pending s after death 2 Accident investigation 1 ☐Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5 To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 34 CANP 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Schuller CENF 30. Name and add ss of person who completed cause of death (Item 23a) (Type, Print) Pagadena, MD 21122 7900 Oak Point Schuler 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 1 4 2010 Registrar

DHMH 17 Rev 1/2001

	1 = For State Registrar	State of Maryla		ment of He ficate of De			ene	39379
Physician/ Medical	1. Decedent's Name (First, Middle, Last Florence	R.	Vuit	ch		. Date of Death		3. Time of Death 3:58 p. M
Examiner Funeral Director	000 20 0330	Dr. #911	rs. last birthday)		pring f Under 24 Hrs. 8	Date of Birth (Month, Day, Y	4c. County of Death Montgomer (ear) 9. Birth County New New 1929	
Maryland 28a-f show otified at	Usual Residence of Decedent		City, Town or Location				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10d. Inside City Limits 1 ☐ Yes 2 🗓 No
Jeath with the Maryland items 23a or 28a-f sho ler must be notified at Funeral Director	10e. Street and Number 15115 Interlachen	Dr. #911		10f. Zip Code 20906			nited Stat	
~	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	If Ye	Decedent of Hispa s, specify Cuban, N Yes 2 🔼 No S	anic Origin? (Specify Mexican, Puerto Ric Specify:	Yes or No- an, etc.)	14. Race - Ameri Black, White, Specify: Wh	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam pace. To Be Completed by	15. Decedent's Edi (Specify only highest grace Elementary/Seconday (0-12)	cation le completed) College (1-4 or 5+)	(Give kind life. DO N	's Usual Occupatio of work done durii OT use retired) inistrato	ng most of working	1	6b. Kind of Business Ir Medical	ndustry
yland id be filed volumer when the filed volumer with earth other attic event,	17. Father's Name (First, Middle, Last) Ernest	Robin	nson	18	3. Mother's Name <i>(Fi</i> Mabel	irst, Middle, Ma	iden Surname) Kirl	эу
B, Mar and 2 shou dealth and sm 27 is m her traum	19a. Informant's Name/Relationship (Typ John Vuitch / Son		1201 At	wood Rd.	Number or Rural Ro		tity or Town, State, Zip MD 2090	
timore t. Page 1 street of Herant, If ite	20a. Method of Disposition 1	Removal from State Ch	o. Place of Disposition cemetery, cremato nesapeake	ry or other place) Cremator	,,	/2010	Oc. Location - City or T Beltsville	, MD.
Ball permi Depar Impor any in	21. Signatur o Fu (ra) Service License	N	M0098 933	3 Gist Av	ve. Silven	Spring	g, Maryland	ion Service 1 20910
rnysician/ Medical	23a. Part 1. Enter the disease, of complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	lastoma Mu			spiratory arrest	- 1	Approximate Interval Between Onset and Death months
Examiner	Sequentially list conditions, if any, leading to immediate	. Due to (or as a conse	equence of):					
icate be executed physician and such burial-transit	Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a conse	equence of):			<u> </u>		
Box 68 death certif ne attending ed for use a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	ac. If yes, outcome of preg 1	etal death 3 🔲 Ect	topic pregnancy ner (specify)			23d. Date of deliv	ery Day Year
ds, P.C quires that en signed t buld be det	Part II. Other significant conditions con Diabetes Mell			lying cause given i	n Part I.		cco use contribute to the	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by the din by the funeral director, page 2 should be detach. I Certificate: To Be Completed by Physicians.	25. Was case referred to medical					24a. Was an autopsy performe 1 Yes 2 \$\int_{\text{Y}}\$	d? prior to co	osy findings available mpletion of cause of 2 No
Vital hysician: his certific	examiner?	spital:			of Death (Check only			
on of \\ nding Phy ath. r: After this e funeral c	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	ER/Outpatient 3 28b. Time of injury	work?	28d.	5 🖾 Residence Describe how i	e 6 Other (Specify)
Division of train or Attending Ports after death. The Director: After the field in by the funeral Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Speci	home, farm, street, fa ify)		28f.	Location (Stree City or Town, S	et and Number or Rural state)	Route Number,
the Hospital thin 24 hours the Funeral mpleted filled	only one) 3 Certifying Nurse	ian: To the best of my known: On the basis of examination Practioner: To the best of recommendation	ion and/or investigation	on, in my opinion, de occurred at the time	eath occurred at the t e, date and place, an	ima data and n	lace and due to the cou	sea(s) and manner stated
	29b. Signature and title of certifier	m		29c. License nun D2395			Date signed (Month, L	
10	30. Name and address of person who con Burt I. Feldman 31. Date filed (Month, Day Year) and a	M.D. 3305	N. Leisur		Blvd., Si	lver Sp	oring, MD	20906
State Registrar DHMH 17 Rev 7/2009	31. Date filed (Month, Day Year) 2010	32. Registrar's Sign	T. facks					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 8. Date of Birth last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Min Director Usual Residence of Decedent show 10a. State 10b. County with the Maryland must be notified at City. Town or Location 10d. Inside City Limits Funeral Director 28a-f 1 Yes 2 No timore ö 10f. Zip Code 10g. Citizen of What Country? items 23a permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Never Married 2 Married 9 Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done of life. Do NOT use retired) during most of working College (1-4 or 5+) Sa Be ather's Name (First. er's Name (First, Middle, Maiden Surname မ Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p any injury or conce. ▶ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signa re of Funera Pervice Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day Year 2 No has been signed by the e 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? Yes 2 No certificate 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident neral Director: A Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death ęm 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Medical Patricia Inez Wilhelm 2010 December 12:55 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Towson Under 1 Year Baltimore . Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** 8 Date of Birth 1 🗆 M 2 🛛 F Months Davs Hours Min (Month, Day, Ye 5/1/1943 Director 217-40-1573 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2X No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 322 1/2 Townsend Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2X Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: Completed 3 Divorced 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meg Elementary/Seconday (0-12) College (1-4 or 5+) Teacher School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Crowson Philomena Onteri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessica Wilhelm (Daughter) 20a. Method of Disposition 8416 Coco Road Rosedale, Maryland 21237 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 12/16 4 ☐ Donation 5 ☐ Other (Specify) <u> Holly Hill Memorial Gardens</u> Middle River, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) deen Medical Due to (or as a consequence of): Examiner ton 1 DOUND Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death. signed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Pregnant at time of death 5 Other (specify) Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 X No after death.

Director; After this certificate 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 Tes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 K Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of contifier 29c. License number MD

State

Registrar

ARATHI

31. Date filed (Month, Day, Year)

Barre

ou MD 21204

4105

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

701

32. Registrar's Signature

State of Maryland / Department of Health and Mental F State Certificate of Death	Reg. No. 19382
1. Decedent's Name (First, Middle, Last) 2. Date of	Death 3. Time of Death
	2/10/2010 Year 9:31 P M
Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
Carroll Hospice Dove House Westminster 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of	Carroll 9. Birthplace (State or Foreign
Director 092-60-4434 1 □ M 2 ☑ F 47 Yrs. Months Days Hours Min. 2/21,	Today, Year) Country) NY
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
The same of the sa	1 ☐ Yes 2 🌣 No
W R R R R R R R R R R R R R R R R R R R	10g. Citizen of What Country?
To be set of the set o	USA
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Normed Forces) If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
Armed Forces? Armed Forces? If Yes, specify Cuban, Mexican, Puèrto Rican, etc.)	Specify: White
Property of the property of th	16b. Kind of Business Industry
(Give kind of work done during most of working life. DO NOT use retired) [Specify only highest grade completed] [Specify only highest grade completed] [Specify only highest grade completed] [Give kind of work done during most of working life. DO NOT use retired]	ř.
Administration 2 Administration 18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	MD Div. of Corrections
To be a specific to be	,
The first of the f	
Debbie Cremen/Sister 20a. Method of Disposition Debbie Cremen/Sister 20b. Place of Disposition (Name of Date	
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	20c. Location - City or Town, State
Proposed and the properties of	Pikesville, MD
1 XBurial 2 Cremation 3 Removal from State St. Charles Cemetery 12/14/10	ome & Crematory, P.A.
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line.	
Physician/ Immediate Cause (Final disease or condition By east Con CU	et and Death
Medical resulting in death) Due to (or as a consequence of):	1
Sequentially list conditions, b. Due to (or as a consequence or):	
The part of the course of the	
That initiated events resulting in death) Last Due to (or as a consequence of):	
Sequentially list conditions, light of the conditions of the cause. Enter Underlying Cause (Disease or ilinjury that initiated events resulting in death) Last Sequentially list conditions of the cause. Enter Underlying Cause (Disease or ilinjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
	COL Data of delivery
We have the part of the part 12 months? If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year
G the state of the	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	tobacco use contribute to the cause of death?
e equipment of the control of the co	Yes 2 No 3 Probably 4 Unknown
Records, The law requires cate has been signated and been signate	s an 24b. Were autopsy findings available prior to completion of cause of death?
The state of Death (Check only one) 1	s 2 No 1 Yes 2 No
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Re	sidence 6 Other (Specify) Hospice
27. Manner of Death 28a. Date of injury 28b. Time of injury at work?	how injury occurred
28d. Described September 1	(0)
25. Was case referred to medical examiner? 1 Yes Year) 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Referred to medical examiner? 27. Manner of Death Natural 5 Pending Investigation 28b. Time of injury 28b. Time of in	(Street and Number or Rural Route Number, wn, State)
FFEMALE: 23c. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Yes 2 No Yes Ye	ause(s) and manner as stated.
The property of the property o	ha causa(s) and marrier as stated.
29b. Signature and title of certifier 29c. License number 1 4113 9	29d. Date signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	57 1),0010
	0 1 1: 15 010//
Clement B. Knight, M.D., 10710 Charter Drive, Suite G020,	Columbia, MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 2010 0504 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ALTZMORE WASHZUBTON MEDICAL CENTER GLEN BURNIE TUNE ARUNDE Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth Month, Day, Year) Days 1 - M 2 - XF Director 219-80-0213 43 MD Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 XNo Anne Arundel Glen Burnie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 327 Ferndale Road 21061 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) Coilege (1-4 or 5+) 12 Hair Care Hairdresser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Kenneth L. Hertz Shirley M. Kiley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, Maryland 21061 Mr. Kenneth L. Hertz / father 327 Ferndale Road, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12/13/2010 Atlantic Crematory Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD Mo135 Singleton Funeral & Cremation Services, P.A. Vam 23a. Part 1. 1 er the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or harm ailure. List only one cause on each line. Immediate Cause (Final ACUTE HYPARIC Onset and Death Physician/ RESPIRATORS disease or condition Medical resulting in death) **Examiner** PIRATZON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed **ACUTE** PANCREATITIS Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Dav Pregnant at time of death 2 No 9 Unknown 9 Vinknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by ELEVATED MI 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ha 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 🕱 No ၉ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) injury 5 Pending 2 🗆 No after death

Director: A

in by the fi Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certifier D0069274 to zhave DECEMBER 11, 2010

Registrar
DHMH 17 Rev 7/2009

State

GLEN BURNZE.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

4

301 HOSPITAL DRIVE,

32. Registrar's Signature

		1 State of Maryland / Department of Health and M Certificate of Death	1ental Hy	7 11 1	0 09384
		Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of De	Reg. No.	3. Time of Death
Physicia		Mary Kathleen Wade	Month	per 10, 20	ar
Medic Examir		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	Decemi	4c. County of D	
		Baltimore Washington Medical Center Glen Burnie		1	rundel Co.
Funeral	г	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Bir	th g.	Birthplace (State or Foreign
Director		217-80-3833 1 M 2 X F 84 Yrs. Months Days Hours Min.	(Month, Da	1926 1	Country) Maryland
d to w	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
arylan a-f sh iied a	[왕	MD			1 ☐ Yes 2 🕅 No
ne Ma	ă	Anne Arundel Odenton 10e. Street and Number 10f. Zip Code		10g. Citizen of What	
/ith th	Funeral Director	10.29 666			
ems r mu	ű,		cifv Yes or No-	United	States merican Indian.
or it	by F	Armed Forces? If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, W	hite, etc.
urs afte tural", c		3		Specify: V	√hite
2 hou	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working)	na .	16b. Kind of Busine	ess Industry
hin 7	Ë	Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use retired)	9		
d with the rit, the rit, the	Be C	12 yrs. Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name		Own Ho	ome
did be filed ental Hy ked oth	100	17. Father's Name (First, Middle, Last) 18. Mother's Name William M. Lowman Kathlee		,	
ould I		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural			
Mithar althar 27 is r trau	li		evern,	· ·	Zip Code)
1 and		20a. Method of Disposition 20b. Place of Disposition (Name of	ate	20c. Location - City	or Town, State
partitioner, Inderylating ZIZIO-0000 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be notified at once.	3	1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Mondowridge Mem Powle 12/15	: /2010	Filendae	Marry land
Dalti permit. I Departin Importa any inju		21. Signature of Funeral Service Licensee Meadowridge Mem Park: 12/15 22. Name and Address of Facility Sing	1/2010 I	Funeral &	Crometion
	- 0	MO1121 Services PA; 1 2nd A	Ave SW:	Glen Burr	ie. MD 21061
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on such line.	respiratory an	rest,	Approximate Interval Between
Physician/	Q E	Immediate Cause (Final disease or condition	tion		Onset and Death
Medical Examiner		resulting in death) Due to (or as a consequence of):			. 4
	ē	Sequentially list conditions, b.			Papears
si g. 1	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or lining)			> 10 years
ecution and all-tran	Еха	that initiated events resulting in death) Last C. Due to (or as a consequence of):			10 years
ate be executed hysician and the burial-transit	dical	C _d			
Attending Physician: The law requires that the death certificate be executed at death. Attending Physician: The law requires that the death certificate be executed ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burrial-transit	Jed	la service			
ath certifica attending p	an/l	IF FEMALE: 23b. Was decedent pregnant in the post 12 months? 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of	delivery
death	sici	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
that the deaned by the a	Physician/Me	9 U OTIKIOWII	T		
s tha ignec	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?
requires been sig should b	sted		1	Yes 2 ☑ No 3 □	Probably 4 Unknown
law r has b	Completed		24a. Was autor	prior t	autopsy findings available to completion of cause of
The Is icate ha			1 🗆 Yes	rmed2 death	Yes 2 No
sician certif recto	Be	25. Was case referred to medical examiner? 1 Yes 2 V No Hospital: 6. Place of Death (Check o	only one)		
Phys this ral di	10	27 Manner Deeth 20 Date in 1 inpatient 2 in EH/Outpatient 3 in DOA 4 in Nursing Hom		lence 6 Other (Sp	ecify)
ding th. After fune	Certificate:	1 ✓ Natural 5 ☐ Pending (Month, Day, Year) injury work?	ou. Describe n	ow injury occurred	
Attendi r death. cctor: A	ŧ	3 Suicide 6 Could not be	8f. Location (S	Street and Number or i	Rural Boute Number
al or safte		building, etc. (Specify)	City or Tow	n, State)	iora, ricoto riambol,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check (due to the car	use(s) and manner as	stated.
the H nin 24 the F	Me	only one)	ne time, date a , and due to the	nd place, and due to tr e cause(s) and manner	ne cause(s) and manner stated. as stated.
To Cor		29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	nth, Day, Year)
10		I constit C Aretra MD D001848	0	12/13/	10
10		only one) 3 — Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, 29b. Signature and title of certifier 29c. License number 2	FON	ma di	116
Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature	, ,		· /
Registra		DEC. 14 2010 Present S. Aparkar			

10-09425 Toby Lynn Wean

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

oby Lynn wea	111	1- For State	e or Maryland		artment of H rtificate of D		nd ivientai		eg. No.	
Physic		1. Decedent's Name (First, Middle,L						2. Date of Dea	th	3. Time of Death
Medical Exam	iner	Toby Lyn			14h (City Town	or Location of De	Month Decembe	r 8, 2010 4c. County of	0813 hrs
		4331 Cherry Tree Lane	give street and named ,			ykesville		3411	Carroll	55441
Funeral		015 10 0106	37			f Under 1 Ye			` 1,	Birthplace (State or Foreign
Director			M 2 ^X F	54 ———	Yrs.	VIOLITIES	ays Hours I	Aug. 2	27, 1956	Country) WV
Any		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Location					10d. Inside City Limits
E .	ក	MD	arroll		Syke	sville	9			1 Yes 2 No
Maryland 7 28a-f show	Director	10e. Street and Number			10	f. Zip Code		1	0g. Citizen of What	t Country?
death with the Maryland or items 23a or 28a-f sbo must be notified at once.	a Di	4331 Cherry Tre	e Lane	Even in 11	C 142 M/ss D		1784	(Specify Yes or No	Taa Bass	USA
eath w	Funeral	1 Never Married 2 X Marri	Armed Forces?				an, Mexican, Pue		White,	American Indian, Black, etc.
after d	by Fi		ed If Yes, Give Year or Dates:		1 Ye	s 2 X N	lo s <i>pecify:</i>		Specify:	White
hours "natur	ted	15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade con College (1-4 or		16a. Decedent's L during most of		pation (Give kind fe. DO NOT use		16b. Kind of Busin	ness/Industry
36 thin 72 re. than '	Completed	Elementary/Secondary (0-12)	4	J+)	Crede	ntiali	ing Spec	ialist	Health	Care
15-0036 filed within 72 hours after I Hygiene. d other than "natural", of the Medical Examiner."	S	17. Father's Name (First, Middle, La	•				18.Mother's Na	me (First, Middle, M		
21215-0036 and be filed within 7 Mental Hygiene. marked other than ic event, the Medica	o Be	Harry Bennett 19a. Informant's Name/Relationship			19h Mailing Ad	drass (Str		Roope	pher City or Town	State Zin Code)
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho marke event, the Medical Examiner must be notified at once	F	Mr. Larry L. Wea						ane, Syke		
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental. Important: If iten 27 is marked injury or other fraumatic event.		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from Str		Place of Disposition crematory or other p	(Name of c		Date	20c. Location - C	
Pages Pages ment o		4 Donation 5 Other Speci	fy:	410	County (Cremat				
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: If item 27 is a injury or other traumatic		21. Signature of Funeral Service Lic		27//	22. Name	and Addre	ss of Facility	IGHT FUNE sville, M	RAL HOME	& CHAPEL, PA
Physician		23a. Part I. Enter the disease, or cor	nplications that caused							
Examiner	23 S		each line. a. Atheroscl	erot	ic cardio	vascu	lar dise	ease		Between Onset and Death
		or condition resulting in death)	Due to (or as a conse	equence o	f):					
	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence o	f):					
Λ	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence o	f):					
and transit			d							
60, at be executed hysician and e burial - transit	Medical	X UNPENDED [AMENDEDa,PI	I,27	per ME g	910 1	2/22/10	TT		
6876 certificate nding phy	W/u	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	ne of preg	nancy ₂ Fetal d	eath 3	Ectopic preg	gnancy	23d. Date of de Month	livery Day Year
Box 6876 death certificat the attending phy of for use as the	Physician/N	1 Yes 2 No 9 V Unknow	4 Pregnant at	time of de	eath 5 Other	(Specify)			İ	
D. B t the de by the		Part II. Other significant conditions		but not re	esulting in the under	rlying cause	given in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
r, P.O ries that the signed by	d by	_Chronic alcoho	ol use					1 Yes	2 No 3	Probably 4 V Unknown
ords w requ is been should	plete							24a. Was a autop:	sy prio	re autopsy findings available r to completion of cause of
of Vital Records, as Physician: The law requir Mer this certificate has been si neral director, page 2 should b	Completed							perfor 1 Yes 2		th? Yes 2 No
ital iician: s certif rector,	BB	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	nt 2	ER/Outpatient 3	26.Plac	Other Nur	sing Home 5	Posidoneo 6 2	Othor: Seono
1 of Vital Rec ling Physician: The After this certificate funeral director, page	- T	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	y	28b. Time of Injury		ury at Work?		ow injury occurred	Julei, Scene
ion tendin eath. tor: A	atior	1 X Natural 5 Pending 2 Accident Investiga	(Month, Day,Y	eall)		1	Yes 2 No			
Division pital or Attendir ours after death. reral Director: A	Certification:	3 Suicide 6 Could no determin	28e. Place of In	ury - At ho	ome, farm, street, fa	ctory, office	building, etc.	28f. Location (S or Town, St		or Rural Route Number, City
E G D		29a. Certifier	cian: To the best of my	knowled	ne death occurred s	at the time	date and place is	nd due to the cause	e(s) and manner as	stated
To the Hos within 24 h To the Fust completely	ledical	(er: On the basis of exar and manner stated.							
F 3 F S	Me	29b. Signature and title of certifier	11 8	\			nse number			(Month, Day, Year)
60		Mugho	isnelf, MX	<u> </u>		0.0	.M.E.		December 9,	2010
pero		 Name and address of person who Melissa Brassell, MD 	completed cause of d Assistant Medical	•	•	Street,	Baltimore, M	D 21201		
	tate	31. Date filed (Month, Day, Year)	2. Registrar				•			
Regis	trar	DEC 1 4 201	1 / June	Fil.	13 wu					

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 39385 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 1 Natalie Delano Whitney 2010 12:22P ^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8, Date of Birth Month, Day Yea 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🗓 F Months Hours Maine 004-22-3262 Director 84 January Usual Residence of Decedent artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2X No Montgomery Silver Spring Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4325 Mahan Road 20906 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 ☐ Yes 2 X No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other two-Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Julian Francis Delano Priscilla Atwater 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Whitney / Son 8590 Mitchell Road, La Plata, Maryland 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) December 17. Parklawn Memorial Park 2010 Rockville, Maryland 21. Signature of Funeral Service Licensee Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 M01596 23a. Part 1) Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tra Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: <u>ا</u> 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State Medica 29a. Certifier 1 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and 29d. Date signed (Month, Day, Year) 70061302 10 30. Name and dress of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20814 Rohatgi M.D. Atu1 31. Date filed (Month, Day, Year) Registrar's Signat State DEC 4 Registrar

PB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elinor Adams Wray December 4, 2010 11:58 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chevy Chase 5100 Dorset Avenue #214 Montgomery Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🏝 F Days Aug. I , Months Min 98 036-10-0066 Î912 Rhode Island Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Chevy Chase Maryland Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be r Funeral 5100 Dorset Avenue #214 20815 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Give Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Broker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Adams Hazel Proal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10204 Clearbrook Place, Kensington, Maryland 20895 Rochel Roland/Guardian Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Quidnessett
Memorial Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🕮 Burial 2 🗌 Cremation 3 🗌 Removal from State December 15 North Kingstown, 2010 4 Donation 5 Other (Specify) Rhode Island Bethesda-Chevy Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home Robert A. Pumphrey Funeral Home/ Chase Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814–3501 M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiac Arrest Physician Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions. Examiner if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Dementia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Hospital 1 X Yes 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifie 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature ar ertifie 29c. License number 29d. Date signed (Month, Day, Year) D29353 December 6, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George W. Graves, M.D. 5530 Wisconsin Ave. #1400, Chevy Chase, Maryland 20815

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 1 0 bay Dec. 11:55A M Julia Marie Yoder Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Sykesville Brinton Woods Rehabilitation 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F Months Days Hours Min (Month Director 199-14-2451 86 PA 24-1924 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State Director 10c. City. Town or Location 10d. Inside City Limits MD Carroll Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21157 1703 Bachman Valley Rd. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: white Completed 3 ₩ Widowed 4 Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Manufacturing Elementary/Seconday (0-12) College (1-4 or 5+) Riveter 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Allen Currens Hazel Kepner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy C. Tyree-daughter 1703 Bachman Valley Rd., Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12-14-10 **F**airfield, PA Fairfield Union 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home 254 E. Main St. Westminster, MD21157 21. Signa ure of Ferneral Service Licens homas 254 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on pach line. Ons an eath Immediate Cause (Final 4278105CCCROTIC Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Pregnant at time of death 5 Other (specify) Month Day Year signed by the a ld be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe

within a set of the safer death.

To the Funeral Director. After this certificate has I Be ပ္ Certificate:

1 Yes 2 No 2 1 26. Place of Death (Pheck only one)

	2 Accident	Investigation		М	1 🗌 Yes	2 🗌 No	
	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif		ry, office		28f. Location (Street and Number or Rural R City or Town, State)
2	9a. Certifier 1	Certifying Physici	an: To the best of my know	ledge, death occured	at the time, date	and place, a	and due to the cause(s) and manner as stated.

5 Pending

2 → No

25. Was case referred to medical examiner?

1 Tes

27. Mann of Death

1 Natural

28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

iniury

2 🗌 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 Nursing Home 5 Residence 6 Other (Specify)

EISTOPSTOLEM

28d. Describe how injury occurred

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title

29c. License number 20806

Other:

29d. Date-signed (Month, Day, Year) 2010

21(36

and address of person who completed cause of death (Item 23a) (Type, Print) JEMS UD ISUSINUSS C

Hospital:

31. Date filed (Month, Day, Year) DEC 1 4 2010 32. Registrar's Signature

State Registrar

edical

			1- For Amend Items 23e, 24a, 25, 26, 27, 29a Registrar Cert	rtment of H Per dr. tificate of L	lealth and Mental 28910,12/1472 Death	670 and 10 39389				
	Physic	ant	1. Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death						
	/Medi		Mary Elizabeth Young	Month Day Year November 27 2010 1:36						
1	Exami	ner	.4a. Facility Name (If not institution, give street and number) 6309 Knoll Hill Drive	4b. City, Town, or		4c. County of Death				
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Berlin If Under 1 Year		Worcester				
	Director		577-32-6111 1 M 2 F 8/4 Yrs.	Months Days	Hours Min. (Month	f Birth h, Day, Year) 9. Birthplace (State or Foreign Country) Washington DC				
	pu »		Usual Residence of Decedent		July					
	f sho	ō	10a. State 10b. County 10c. City, Town or Loc			10d. Inside City Limits 1 ☐ Yes 2 📉 No				
	the N	Funeral Director	MD Worcester Berlin	1 10f. Zip Code		10g. Citizen of What Country?				
	3a or	a D	6309 Knoll Hill Drive	Toil Zip Godo	21811	USA				
	ems 2	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Warmed Forces?	as Decedent of His	spanic Origin? (Specify Yes on, Mexican, Puerto Rican, etc.	r No- 14. Race - American Indian,				
36	hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be coffilled at	by Fu	I Never married 2 Married I Yes 24 No	Yes 21☑ No	Specify:					
Ö	hours tural		Year or Dates:	71		Specify: white				
212	in 72 in "nat	Completed	(Specify only highest grade completed) (Give ki	ent's Usual Occupa ind of work done du O NOT use retired)	uring most of working	16b. Kind of Business/Industry				
21,	d within /giene. er than "	Com	College (1-40) 5+)	lephone o		communications				
nd	be filed tal Hygi d other event,	Be (17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Mic	ddle, Maiden Surname)				
ryla	should I and Men s marke umatic	မ	Alfred Jenks Bell		Clara Diet					
Mai	d 2 sho Ith and I7 Is ma trauma	1			nd Number or Rural Route No 111 Drive Berl	umber, City or Town, State, Zip Code) in • MD 21811				
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the IV deal Examiner must be refulled at		20a. Method of Disposition 20b. Place of Disposi	ition (Name of	Date	20c. Location - City or Town, State				
E O	Pages nent of I ant: If ite ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Copecify)	atory`or other place,)					
aĦ	permit. Pages 1 a Department of Hes Important: If item any injury or othe once.			Name and Address	s of Facility	II. D. L.				
<u> </u>	99 = 9 9		Raltimore MD 21201							
	Physician	2	23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between							
			Immediate Carse (Final disease or condition resulting in death) a. Nonic obstructive pulmonary of Carte (Final disease) a. Nonic obstructive pulmonary of Carte (Final disease)							
	/Medical Examiner		Due to (or as a consequence of):		U					
بتعز		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
	cut mand nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.							
o,	e exe	Exi	resulting in death) Last Cue to (or as a consequence of):							
8760,	icate be execurated physician and the burial-transit	dical	d							
× 6	death certificate be exec e attending physician and d for use as the burial-tr	Physician/Me	IF FEMALE: 23h Was decedent pregnant 23c. If yes, outcome of pregnancy							
Box	leath aften for u	cian	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year				
О	at the de by the tached	hysi	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ 0 9 ☐ Unknown 9 ☐ Unknown	Janei (Speelly)						
ς, π	law requires that the as been signed by the 2 should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given	n in Part I. 23e. D	old tobacco use contribute to the cause of death?				
Records,	w require s been signations to the state of	ted t	Haial phillation		1	☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown				
ecc	law r las be	plei			24a. V	Vas an 24b. Were autopsy findings available prior to completion of cause of				
	: The law cate has	Completed			p 1 □ Ye	erformed? death?				
Viital	ician certifi ector	Be	25. Was case referred to medical examiner? Hospital: Hospital:	0.11	26. Place of Death (Check or					
_	this all din	은 .	1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 □ Nursing Home 5 🖸 Residence 6 □ Other (Specify)							
Division of	or Attending F after death. I Director; After d in by the funer:	tion	1 X Natural 5 Pending (Month, Day, Year) Injury 2 Accident investigation	28c. Injury a Work? M 1 □ Ye	es 2 \(\subseteq No	be how injury occurred				
<u> S</u>	Atter	Hick	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street		28f. Locatio	n (Street and Number or Rural Route Number,				
ă	tal or rs after all Dir	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or	Town, State)				
	40spi 4 hou Funer ely fil		29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my knowledge, death of the basis of examination and/or inversions.	occurred at the time	e, date and place, and due to	the cause(s) and manner as stated.				
:	To the Hos within 24 h To the Fun completely	Medical	one) and manner stated. 29b Signature and title of certifies.							
	2 ½ ½ %		A A A A A MA	29c. License r	55906	29d. Date signed (Month, Day, Year)				
		-	30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	int)		140210				
			LUCY VAN VOORHEES 314 FRA	WKLIN	JADE SOI	TE 402 BERLIN				
	Stat		31. Date filed (Month, Day, Year) DEC 14 2010 Annua S. Again	Kel	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	102011				
	Registra	r	NEC 1 4 2010 June B. Jan	Na man						

		For State	State o	of Maryla		artment of I rtificate of I	Health and i Death	Mental Hy	- /	2011	1 0	0000
		Registrar 1. Decedent's Name (First, Middle,	, Last)		Cei	tincate of t	Jean	2. Date of De	Reg. No.		3.	Time of Death
Physicia Medic		Elizabeth Altm	an					Novemb	er 2	4, 201	.	11:30P ^M
Examin		4a. Facility Name (if not institution,	give street and num	nber)	-	4b. City, Town, o	r Location of Death			County of De		
		3620 Littledale Road Apt. 110 Kensington [5. Social Security Number							Montgomery		Otata au Farrian	
Funeral Director		370-22-8592	6. Sex 1 □ M 2 XF	7. Age (In yrs.	6 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da June 8	ay, Year)	4 H11	ountry) ngary	(State or Foreign
»o	,	Usual Residence of Decedent		1				Danc O				
ryland I-f sh	ctor	10a. State 10b. County			City, Town or Lo							nside City Limits
ne Ma or 28a notif	Dire	MD Montgo	mery	Ken	singtor	10f. Zip Code			10o. Citi:	izen of What C		ZZ 163 Z - 160
with t	Funeral Director	3620 Littledale	Road Apt	. 110		20895			USA			
death item: ner m		11. Marital Status	12. Was Dece Armed Fo	dent Ever in U	J.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Am Black, Wh		dian,
s after ral", or Exami	d by	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 🔀 Divorced	If Yes, Giv	e		1 ☐ Yes 2 X No	Specify:			Specify: Wh	,	
hours natural E	lete	15. Decedent's Education				16a. Decedent's Usual Occupation			16b. Kind of Business Industry			
in 72 Je. Than " e Med	Completed	(Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired) (Give kind of work done during most of life. DO NOT use retired)								!		
d with hygier sther t	Be C	12 17. Father's Name (First, Middle, Li	act)		Admir	nistrativ	e Assista 18. Mother's Nam			pital		
Wally fall (2 12 13-0050) 2 should be filed within 72 hours after death with the Maryland 2 should be filed within 72 hours after death with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at	10	Louis Trattner	331/				Irene Oh			rumame)		
ary should and M is mar	J (8	19a. Informant's Name/Relationsh					and Number or Rui				Zip Code)	
ind 2 steath im 27 her tra		James I. Altmar	ı/son				ue Takoma	a Park,				
Page 1 a		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from	State	cemetery, crer	nsition (Name of matory or other place		Date	l	cation - City o		state
그 무원을 다		4 ☐ Donation 5 ☐ Other (S _i 21. Signature of Funeral Sent ice Li		//			matory 1					0.4
Departiment of the control of the co	1	Dwell 7	fle lit	Se M	GC 1251 Be	oing Home	s Cremation	on Servi	ice Cla	rksvil	ox /	54 MD 21029
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										
Physician/ Medical		Immediate Cause (Final disease or condition Thrombocytopenia Onset and Death										
Examiner		resulting in death) Due to (or as a consequence of): Essential Hypertension										
_	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
cuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c										
roate be executed physician and sthe burial-transit		resulting in death) Last Due to (or as a consequence of):										
icate k	ledical		d									
certif ending	sician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			☐ Ectopic pregnan	CV		2	23d. Date of d	lelivery	
that the death certification by the attending detached for use as	/sici	in the past 12 months? 1						Month	Day	Year		
at the	/ Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contrib						se contribute	to the cau	use of death?		
uires th	ed by	1						1 🗆	Yes 2 No 3 Probably 4 Unknown			
aw requires as been sig 2 should b	Completed								24a. Was an autopsy findings prior to completion of			ndings available
The la	Com							perfe	ormed? 2 X No	death?	es 2 \square	
sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				lace of Death (Chec	k only one)				
Physi r this c rral dir	∋: To	1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Resi							idence 6 Other (Specify) how injury occurred			
nding ath. r: Afte	ertificate:	1 X Natural 5 Pending (Month, Day, Year) injury work? 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					:?					
or Attending Physician: The law requires that the death certificate be executed after death. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	ertii							28f. Location (Street and Number or Rural Route Number, City or Town, State)				
pital cours a cours a filled i	cal C											
To the Hospital or Attending Physical Within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical	29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner a only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and date and due to the cause						and due to the and manner	e cause(s) as stated.	and manner stated.		
To th withii To th	-	29b. Signature and title of certifier	/ MD			29c. Licens	29c. License number 29c		29d. Date	ld. Date signed (Month, Day, Year)		
						D6319	6		Nove	mber 2	6, 20	010
15		30. Name and oddress of person watthew McAndre					kville. M	1D 20850)			
Stat	e	31. Date filed (Month, Day, Year)	32. 5	egistrar's Sign	aturos							
Registra	ar	LLC U L	2010 CK	CREEKING .	D. 18	arked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November Steinhofel 29, 2010 7:50 A M Hilda Arur Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Harmony Hall Columbia Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2💢 F Months Hours Min. (Month, Day, Year) ct 5, 1928 New York **Director** 131-20-6511 82 Usual Residence of Decedent show 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Columbia 1 Yes 2 X No Maryland Howard ould be filed within 72 hours after death with the I Id Mental Hygiene. marked other than "natural", or items 23a or 2 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 10425 Owen Brown Road 21044 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natur ury or other traumatic event, the Medical Iury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) <u> Licensed Practical Nurse</u> Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Steinhofel Carl Anna Kurtz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shanta N. Arur/daughter 10425 Owen Brown Road Columbia, Maryland 21044 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 12/2/2010 Woodbine, Maryland permit. . Sign we of Funeral Service Licenses 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 thomas uanita M00957 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Alzheimer's Dementia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate

Cause (Disease or linjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the attending physician and the for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No Day Pregnant at time of death 1 Yes 2 g 9 Unknown detached is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an page 2 s After this certificate has prior to completion of cause of death? autopsy perform 1 🗌 Yes 2 No 2X No completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 2 Other (Specify, Assisted-Living 2 🔀 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 X Natural 5 Pending 2 🗌 No Accident Suicide s after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital within 24 hours a To the Funeral C Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the hasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who Andy Lazris, M

31. Date filed (Month

M.D.

Cedar Lane, Suite 103

ompleted cause of death (Item 23a) (Type, Print)

egistrar's Signatu

RECORD

6334

D47447

November 29, 2010

Columbia, Maryland 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Raymond Edward Anderson 3:05 P Nov 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Charlotte Hall Veterans Home Charlotte 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours March 17, 1 ₩ M 2 □ F Months Î918 Mary land 92 Director 213 09 9015 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a State 10d. Inside City Limits 10c. City, Town or Location Director Maryland Prince George's Brandywine 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 15801 Westwood Road 20613 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify WII Completed 3 ⅓ Widowed 4 ☐ Divorced White the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) 8th College (1-4 or 5+) Hardware Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked ot ဂ Elsie Randall Robert Lee Anderson permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Anderson (Daughter) 15801 Westwood Road, Brandwine, MD 20613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov 24,2010 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State Forestville, Maryland Epiphany Episcopal Church Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Road, Clinton, MD 20735 f Funer Jervice Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ZHEIMER'S Physician/ disease or condition Medical resulting in death) * Examiner Sequentially list conditions, Examiner ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence on and -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death ed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARTERY DISEASE CORONARY 2 No 3 ☐ Probably 4 ☐ Unknown has been sig e 2 should b ESSENTIAL HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate ha irector, page 2 death? 2 🗌 No 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Yes မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending thin 24 hours after death.

the Funeral Director: All ompleted filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Fractioner To the best of my knowledge, 29b. Signature and title of confifier 29d. Date signed (Month, Day, Year) D0067788 MD 11.22.2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEENA RAO KODALI

State

Registrar

31. Date filed (Month, Day, Year)

NOV 29

back

32. Re y trar's Signature

Leneur

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 9:00 PM 2010 ROSALINA NMN AGUILAR Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL INSTITUTES OF HEALTH **BETHESDA** MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Mex<u>ico</u> 1 □ M 2 🛣 F Hours (Month, Day Director Usual Residence of Decedent 28a-f show 10a. State 10b, County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director Queens 1 Yes 2 No NY Corona 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11368 3812 111th St. #2B Mexico Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?...
1 Yes 2 XNo Black, White, etc ş 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2 No Specify: Mexican If Yes, Give Year or Dates Specify: Mexican 3 Divorced 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important. If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nail Salon Nail Technician 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elena Palma Rosas Lazaro Aguilar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3812 111th St. #2B Corona, NY 11368 Pascual Torress/Friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Santa Maria 12/5/2010 4 Donation 5 Other (Specify) San Pedro Cemetery Tronconal 22. Name and Address of Facility Marshall-March Funeral Home Signature of Funeral Service Licer DC 20011 4217 9th St. NW Washington, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Re Physician/ hactor disease or condition year Medical resulting in death) Due to (dr as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) for use as the burial-transit Hospital or Attending Physiclan: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Other (specify) Month Day Year Pregnant at time of death ned by the a e detached f g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signe should be a Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a, Was an cate has I autopsy performed^a within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag 2 N Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 21 No 욘 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No iniury 1 1 Natural 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d, Date signed (Month, Day, Year) 23357 201 Voora Do (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death CHOWDHURY ROOPA NE 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 31. Date filed (Month, Day, Year) State NOV 3 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 10:15 PM Louise Blakey November 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Golden Living Center Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) ct 3, 1943 1 □ M 2 🛣 F Months Days Hours Min. Yrs. Director Washington, DC 577-56-9977 67 Usual Residence of Decedent 28a-f shov 10b. County be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Hagerstown Maryland Washington 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23amust 11400 Stonecroft Court, Apt 208B 21742 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, zr is marked other than "natural", or iter traumatic event, the Medical Examiner Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Completed 3 X Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation

Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4 Registered Nurse Nursing Homes and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ge 1 and 2 should be fint of Health and Mental It item 27 is marked of 2 Kendall Donald Blakey Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Wiley/daughter 10302 Caspian Way New Market, Maryland 21774 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 Department of I Important: If its 1 Burial 2 Cremation 3 Removal from State Injury 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 11/27/2010 Woodbine, Maryland Rinal ure of Funeral Service Lie Going Home Cremation Service P.O. Box 784 'n Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Examin and I-transit Due to (or as a consequence of): attending physician if for use as the burial-Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day ed by the a 1 ☐ Yes 2 ₩ 9 ☐ Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 0 N certificate 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending

68760 Box P.O. Records, of Vital To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir Division

Certificate: 1 Tyes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of contifier

State Registrar 31. Date filed (Month, Day, Year)

, MD 212

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Bindu Joseph, M.D.

10

egistrar's Signatur

eneur

6001 Muncaster Mill Road Rockville, Maryland 20855

Months

7. Age (In vrs. last birthday)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City. Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Days

Westminster

Min.

Hours

8. Date of Birth (Month, Day, Ye March 3, 71 Director 214-36-9858 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.

The strick flear 27 is marked other than "natural", or items 23a or 28a-f show that that the structural that the structural that the structural to other traumatic event, it is a Modes Exprised in Directo Maryland Carrol1 Mt. Airy 10e. Street and Number 10f. Zip Code 7471 Watersville Road 21771 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No à Specify. 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hardware sales lady 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Larley S. Bonnette Anna Howard 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7461 Watersville Road, Mt. Airy, Maryland Rozzetta Delph - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition Department of Important: If it any Injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Pine Grove Cemetery 12-3-2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home Camille eline 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 2 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trar resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 Tyes 2 PNo 9 Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 24a. Was an certificate 1 □Yes 2 12 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis ar's Signature

1 - For State Registrar

Dove House

5. Social Security Number

Physician

/Medical

Examiner

Funeral

1. Decedent's Name (First, Middle, Last)

Gertrude Marie Bostic 4a. Facility Name (If not institution, give street and number)

6. Sex

1 □ M 2 🔀 F

3. Time of Death

17:19p

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

HOSPICE

1 ☐ Yes 2 X No

Birthplace (State or Foreign Country)

Year

2010

Carrol1

Year) 1939 Pennsylvania

14. Race - American Indian

Hardware Store

20c. Location - City or Town, State

23d. Date of delivery

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown

death?

29d. Date signed (Month, Day, Year)

1 ☐ Yes

autopsy performe Were autopsy findings available prior to completion of cause of

2 No

Mt. Airy, Maryland

white

4c. County of Death

10g. Citizen of What Country?

16b. Kind of Business/Industry

USA

Reg. No.

28

2. Date of Death

November

Month

9	0	0	\bigcirc	,
1,0	2	0	J	0

Registrar

Medical

State

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Carolyn Oconnor MD 1380 Progress Way, Eldersburg, Maryland 21784 Suite 110

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 22, 2010 Physician/ Edward McPherson Baldwin, Sr. 5:50 рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6801 Hungerford Road Charles Bryans Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Feb. 1, 1924 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 📉 M 2 🗆 F Hours Maryland 217-18-2436 Director 86 Usual Residence of Decedent 28a-f show 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 XNo Maryland Charles Bryans Road 10e. Street and Number 10g. Citizen of What Country? Funeral 6801 Hungerford Road 20616 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Tyes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. Specify: White WWII Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Inspector Charles Co. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) item 27 is marked of Randolph Mason Baldwin Sadie Eleanor Elliott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health a Important: If item 27 i Emma Lou Baldwin Wife 6801 Hungerford Rd., Bryans Road, Md. 20616 20b. Place of Disposition (Name of cemetery, crematory or other placeNov. 27, 2010 20a, Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 4 Donation 5 Other (Specify) Trinity Memorial Gardens Waldorf, Maryland 21. Signature of Funeral S 22. Name and Address of Facility Williams Funeral Home, P.A. any M00668 , Indian Head. Md 4270 Hawthorne Rd. sase, or complications that caused the death. Do not enter the mode of dying, spob as cardiac or respiratory arrest, re. List only one cause on each line. 23a. Part 1. Enter the disc shock, or heart lailur Interval Between Immediate Cause (Final COONSM Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death signed by the a 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ No 3 Probably 4 Unknown 1 🗌 Yes should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide work? injury 5 Pending nours after death.

neral Director: Af Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check To the I within 2 Certifying Nurse Fractioner: To the elest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signa**k**ure ath (Item (3a) (Type, Prir 15+ State NOV 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of M	1arylan		rtment of I		and Men		211	The state of the s	39399
Physicia	ın/	Registrar 1. Decedent's Name (First, Middle, L		4: 0			<u>Jeann</u>		Date of Death	Dave -	Year	3. Time of Death
Medic	al	4a. Facility Name (if not institution, gr		QRI	NE	4b. Citv. Town, o	r Logotion of		1000			520 M
Examin	ier	Northwest				,, ,	ndalls.			4c. County	Balt	imore
Funeral		Social Security Number 6.		-	st birthday)	If Under 1 Year Months Days	If Under 24	24 Hrs. 8. [Date of Birth	ear)	9. Birthp Count	lace (State or Foreign
Director		082-12-9268 Usual Residence of Decedent		89	Yrs.				Month, Day, Y 08/24/	1921		"New York
yland f shoved	ctor	10a. State 10b. County		10c. City	, Town or Loc						10	Od. Inside City Limits
or 28a- notifi	Dire	Maryland				Bal 10f. Zip Code	timore	City	10	g. Citizen of	What Count	1 🛛 Yes 2 🗆 No
with the s 23a c ust be	Funeral Director	7218 Park Hei	ghts Avenu	e, #3(08		2120	8		g. Oilizeir oi		S.A.
death r items iner m		11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S		as Decedent of H Yes, specify Cuba	lispanic Origii an, Mexican,	in? (Specify \ Puerto Ricar	Yes or No- n, etc.)		ce - America ck, White, e	
s after ral", o	ed by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 If Yes, Give Year or Dates.	No WWI	I	☐ Yes 2 🛭 No	Specify:			Specify		White
2 hour "natu	plete	15. Decedent's (Specify only highest	Education			ent's Usual Occup		of workina	11	6b. Kind of B	Business Ind	ustry
rithin 7 iene. r than the Mo	Completed	Elementary/Seconday (0-12)	College (1-4 or	5+)	Ìife. DC	NOT use retired) Fu	rrier			(Cloth	ina
filed wall Hyginal Hyg	Be	17. Father's Name (First, Middle, Las	t)				ľ		st, Middle, Ma	iden Surnam	e)	
uld be I Ment narke natic e	٦		Blumengar	ten					ertha F			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship Michael Burnet	, , ,			Address (Street				-		ode) Vork 11570
of Hez of Hez if item r othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3			ace of Dispos	ition (Name of atory or other place	<u>-</u>	Date		c. Location		
t. Page tment rtant: I		4 Donation 5 Other (Spe	cirs)	Ced	dar Pa	ik Cemet	ery	11/30/	/2010	Param	us, No	ew Jersey
permi Depar Impo any ir		21. Signature of Funeral Service Lice	insee 1	10076	09 22.	Name and Addre	ss of Facility Hamps b	Hines-	-Rinalo	li Fun	eral t Sprin	Home, Inc. g, MD 20904
		23a. Part 1. Enter the disease, or co shock, or heart failure List only	mplications that cause	d the death							Sproch	Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition	a Dr	and	ati	Car	0					Onset and Death
Examiner		resulting in death)	Due to (or as	a conseque	ence of):		(
- + <i>l</i> b	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a conseque	ence of):							
be executed sician and burial-transi	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c	a conseque	ence of:						_	
auth certificate be executed attending physician and for use as the burial-transit	dical I	, and the same of	d	,	,							
rtificate ing phy e as the	Med	IF FEMALE:								T -		
ath ce attend for use	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant	2 🗀 Fetal	death 3 🔲	Ectopic pregnand Other (specify)	су				ate of deliver onth [ry Day Year
the de by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 🗌 Unknown									
requires that the des been signed by the s should be detached	by	Part II. Other significant conditions	contributing to death	but not resu	ılting in the un	derlying cause gi	ven in Part I.		_			cause of death?
requir been s should	letec							_	1 ∐ Yes 24a, Was an			ably 4 Unknown
The law ate has page 2 t	Completed								autopsy performe	d2	prior to com death? 1 Yes 2	npletion of cause of
ysician: 1 is certifica director, p	Be	25. Was case referred to medical examiner?	Hospital:		-		ace of Death			A NO	11 0	- 12:577
Physi r this c eral dir	e: To	1 ☐ Yes 2 No 27. Manner of Death	1 Inpat		R/Outpatient 28b. Time of	3 DOA Oth	4 L Nurs		5 Residence Describe how	- 1		7714
ending sath. or: Afte he fun	ficat	1 Natural 5 Pending 2 Accident Investigation		y, Year)	injury	work			30001130111011	injury cocur.		
or Att	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of In	ury - At hon c. (Specify)		et, factory, office			ocation (Stree		er or Rural F	Route Number,
To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phytompleted filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2.	Medical	29a. Certifier 1 Certifying Ph	nysician: To the best o	f my knowle	edge, death o	cured at the time	, date and pla	ace, and due	to the cause	s) and mann	er as stated	l
the Hithin 24 thin 24 the Fu	Med	only one) 3 L Certifying Nu	urse Practioner: To the	e best of my	and/or investig	eath occurred at th	e time, date a	urred at the ti and place, and	d due to the ca	use(s) and ma	anner as stat	
10		29b. Signature and title of certifier	26/B	1	20	29c. License	Sumber	フタ	1.4	. Date signed	-	_ 100
		30. Name and address of person who	completed cause of	leath (Item :	23a) (Type, Fr	int) - Hay	old Bo	ob, M.	Dr n	1.	1	2010
		31. Date filed (Month, Day, Year)	1501) 6	ar's Signatu	11	1,1905	m/	3/00	Suj	41	V	4061
Stat Registra			MO Le Registr	ar a Signate	pa	3						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Robert Craig Brisbane November 2010 3:35 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth
(Month, Day, Ye)
Dec. 25, If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Davs Hours Min Year) 1946 Washington, DC 216-46-8367 Dec. Director 63 Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shouy or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Gaithersburg 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 10740 Game Preserve Road 20879 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give Specify: 3 Widowed 4 Divorced Completed Year or Dates. Vietnam White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry h and Mental Hygiene.
It is marked other than "r traumatic event, the Med (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) School Bus Driver Montgomery County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert Jerome Brisbane Salle C. Rav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra M. Brisbane/Spouse 10740 Game Preserve Road, Gaithersburg, MD, 20879 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 11/29/2010 | Souls Cemetery Germantown, Maryland 22. Name and Address of Facility DeVol Funeral Home ure of Funeral Service Licenses East Deer Park Dr., Gaithersburg, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Jo the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death
Unknown 5 Other (specify) Month Day Year q 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 N 1 ☐ Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 Yes 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1 🔀 Natural 5 \square Pending Accident 1 Yes 2 No Investigation pleted filled in by the Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital of within 24 hours a Lo the Funeral D Medical XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 0062435

State Registrar

DHMH 17 Rev 7/2009

Rockville, MID 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

MAID

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 25 Day Franklin Keith Borden 2010 Nov Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Rockville Montgomery Montgomery Hospice-Casey House 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) 7 3 8. Date of Birth **Funeral** Days Min. (Month, Day, Year) Feb 15, 1937 1 X M 2 🗆 F **Director** 577-50-9713 73 Usual Residence of Decedent 28a-f show 10b. County "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location Director Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 300 East Franklin Avenue 20901 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 XYes 2 No Black, White, etc. 2 1 Never Married 2 Married hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X Xo Specify. If Yes, Give Korean Year or Dateswar era Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Engineer Own Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file n and Mental H is marked of ၉ Daniel L. Borden Margaret C. Sorrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 strength a Mark Erickson/Executor 25024 Applecross Terrace, Damascus, 27 20b. Place of Disposition (Name of cemetery, crematory or other place)

Brown Chapel 20a, Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 29 1 M Burial 2 Cremation 3 K Removal from State Nov. 4 ☐ Donation 5 ☐ Other (Specify) Vienna, 2010 Cemetery 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Silver University Blvd. W., Part 1. Enter the disease, * con olications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on two e cause on each line. 23a, Part 1. Enter the disease. Immediate Cause (Final COPD Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Due to (or as a consequence of) resulting in death) Last the burial physician Physician/Medical The law requires that the death certificate be Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Left Lung Apical Mass Records. 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 2 🗔 1 Yes al or Attending Physician: The safter death.

I Director: After this certifical of Vital apleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 1 Yes 28 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending Division 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one F00 29b. Signatur**∉ a**nd tit**/e** of certif(e 29d. Date signed (Month, Day, Year) 10 R143201

3. Time of Death

VA

10d. Inside City Limits

1 ☐ Yes 2 No

MD 20872

interval Between

Onset and Death

Day

Year

12:20

DHMH 17 Rev 7/2009

Registrar

State

1355 Piccard Drive, Rockvile, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

CRNP

Debrah Miller,

31. Date filed (Month, Day, Year)

		_	Pleas					k. Ensure A Health and I	_		_	9.
	-	For State Registrar			- Iviai yiai	•	tificate of		·····	Reg. No	2011	39403
Physician		1. Decedent's Name Kathryn		,	эy				2. Date of De Month	Da	y Year	3. Time of Death 9:30 a M
Medic Examine		4a. Facility Name (if	not institution, g	ive street and num	ber)		4b. City, Town, c	or Location of Death			c. County of De	
<i>i</i>				etown Roa			Beth				ontgom	
Funeral Director		5. Social Security No. 274-24-4		. Sex 1 □ M 2 □ x 0F	7. Age (In yrs. i 8	2 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Dec. 7	rth ay, Ye <i>ar)</i> 1, 19	9. 8	Birthplace (State or Foreign Country) Ohio
od at	ڀِ	Usual Residence of 10a. State	Decedent 10b. County		10c. Git	ty, Town or Loc	eation					10d. Inside City Limits
larylar 3a-f sh ified a	ecto	MD	Mont	gomery			hesda					1 ☐ Yes 2 ♣ No
Jeath with the Maryland items 23a or 28a-f show ler must be notified at	Funeral Director	10e. Street and Nun	mber	etown Rd.	Apt.		10f. Zip Code	0814		10g. Ci	itizen of What (Country?
ath wi	nue	11. Marital Status			dent Ever in U.		Vas Decedent of H	Hispanic Origin? (Sp	pecify Yes or No-		14 Page - Am	nerican Indian,
ter de , or ite	হ	1 Never Marri		Armed For	ces? 2 X No	If	Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)		Black, Wh	nite, etc.
ours at atural"	Completed	3 XWidowed	4 Divorced	If Yes, Give Year or Da							Specify: Wh	
ո 72 հ an "na Medic	ğ	(Spe	cify only highest	grade completed) College (1-	1 or 5+)	(Give k	lent's Usual Occup kind of work done D NOT use retired,	during most of wor.	king		Kind of Busines	
l withii ygjene her th t, the					40134)	Home	maker		_	Ow	n Home	
ld be fileo Mental H iarked ott atic even	To Be	17. Father's Name (i	First, Middle, Las B ingham					18. Mother's Nar Flossi	ne (First, Middle, Le Dille	Maiden	Surname)	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na Linda K	•	(Type, Print) Button/Da	ughter		-	and Number or Ru od Drive,				•
Page 1 and nent of Hant of Hant of Hant of Hant or other		20a. Method of Disp 1 Durial 2 4 Donation		Removal from			sition <i>(Nam</i> e of natory or other pla can crem	atory No	Date v. 29 2010		ocation - City o	
permit. Departr Imports any inji		21. Signature of Pur	neral service Lice	ensee		22 50	Name and Addre rancis J Univer	ess of Facility Collins Sity Blvd		l Ho	me Inc	ng, MD 20901
		23a. Part 1. Enter to shock, or hear	the disease, or co	emplications that cay one cause on each	aused the deat							Approximate Interval Between
Physician/ Medical		Immediate Cause (disease or conditio resulting in death)		a	cic Ste							Onset and Death
Examiner			•	Due to (c	or as a consequ	uence ot);						
n = 6	Examiner	Sequentially list co if any, leading to im cause. Enter Under	nmediate rlying	Due to (c	or as a consequ	uence of):						
executed an and rial-transi	Exan	Cause (Disease or that initiated events resulting in death) I	s I	c. Due to (c	or as a consequ	uence of):			-			
rie a	<u></u>			d								
tificate ing phy e as th	Med	IF FEMALE:										
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Completed by Physician/Medic	23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		Birth 2 🗌 Feta nant at time of a	al death 3 🗌	Ectopic pregnan Other (specify)	су			23d. Date of d Month	delivery Day Year
requires that the de been signed by the should be detached	by P	Part II. Other signif Parkin	icant conditions		eath but not res	sulting in the ur	nderlying cause gi	iven in Part I.				to the cause of death?
requir been s	etec								24a. Was			autopsy findings available
The law ite has page 2:	dwo								auto	psy ormed?	prior to death?	completion of cause of
cian: T ertifica ector, p	Be	25. Was case referre		Hospital:				lace of Death (Chec		2	0,	00 2 2 110
Physic this c	ᄋᆝ	1 ☐ Yes 2 ₹	No h	1 🗆 I		ER/Outpatien	t 3 DOA Oth	4 ☐ Nursing H	ome 5 Resident			ecify)
ath. r: After	icate	1 Natural 2 Accident	5 Pending Investigat	(Monti	h, Day, Year)	injury	worl		Zod. Describe i	now mjur	y occurred	
al or Atte s after de il Directo ed in by th	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could no determine	28e. Place	of Injury - At ho g, etc. (Specify		et, factory, office		28f. Location (S City or Tov			lural Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 is	Medical	(Check 2	Medical Exa	miner: On the basi	s of examination	n and/or investi	igation, in my opini	e, date and place, a on, death occurred a ne time, date and pla	at the time, date a	and place	, and due to the	e cause(s) and manner stated
To t		29b. Signature and	title of certifier		7		29c. Licens	e number 5258			te signed (Mon	
6		30. Name and addre		o completed cause	e of death (Item	1 23a) (Type, Pr	zint)					2010
		Gary B.	Wilks,					#211, Bet	hesda,	MD 2	20814	
State Registra			V 3 n 20	16	gistrar's Signa	ture						

10-09248

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Robert Allen Berry	1	For State	tate of Maryla	-		of Healtl		Menta	al Hy	_	Reg. No.	20	10 3940
Physician	/	e gistrar I. Decedent's Name (First, Midd	lle,Last)							2. Date of De		Year	3. Time of Death
Medical Examine		ROBERT		A	BERRY	La or =			D. III		er 1, 2010	0	2155 hrs
	4	la. Facility Name (if not instituti 4000 36th Street # 30		mber)		4b. City, To Mt. Ra		ocation of	Death			ounty of De	
Funeral	5	. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under		If Under		8. Date of E	Birth (MM/DD	/YYYY) 9.	Birthplace (State or
Director		212-72-4072	1XM 2F	45	,	Months	Days	Hours	Min.	NOV.	10 19	65 F°	reignMARYLAND Country)
Š.	_	Usual Residence of Decedent Oa. State 10b. County		Inc. City	, Town or Lo	eation		<u> </u>					10d. Inside City Limits
- A													1 X Yes 2 No
the Maryland n or 28a-f show any tified at once. Director	<u> </u>	MD PRTNC Oe. Street and Number	E GEORGE'S	5	SEAT P	LEASAN' 10f. Zip (10g. Citizen	of What C	
the Man or 24 tiffed a		6209 BALTIC S	TREET				207	43			USA		
eath with the litems 23a or ust be notifie	1	1. Marital Status	12. Was Dec	edent Ever in U		Nas Deceden f Yes, specify	t of Hisp	anic Origin				. Race - An	nerican Indian, 8lack,
er death with , or items 23 r must be no			1 Yes	2 X No					uerto r	(icari, etc.)			
urs afte	<u>:</u> -	3 Widowed 4 Di 15. Decedent's Education (Spe	vorced If Yes, Give Yea or Dates: ecify only highest grad			Yes 2			nd of wo	ork done			SLACK ss/Industry
5-0036 ed within 72 hour hygiene. other than "natu the Medical Exau	1	Elementary/Secondary (0-12)				most of work							,
oggeneration of the control of the c	L	12th			PA	INTER						VATE	
filed v Hygi ed oth true		7. Father's Name (First, Middle					18		,	First, Middle, THOMA		rname)	
ID 21215-0036 should be filed within 72 hours after dand Mental Hygiene. 7 is marked other than "natural", or natic event, the Medical Examiner maric Completed by E1		CHARLES HENRY 9a. Informant's Name/Relation			19b. Mail	ling Address	(Street					or Town, St	ate, Zip Code)
Baltimore, MD 21215-0036 Bernit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon ajury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	L	DELORES BERRY	/SISTER		340	4 PUMP	HREY	DRIV	E D	ISTRIC	T HEI	GHTS,	MARYLAND
Baltimore, MD permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is injury or other traumet		0a, Method of Disposition	n 3 Removal fro		Place of Disp crematory or	osition (Name other place)	of ceme	etery,		Date	20c. Loc	ation - City	or Town, State
Baltimore, permit. Pages I an Department of He Important: If ite	L	4 Donation 5 Other S	pecify:										IARYLAND
Balt Separtiting post	2	1. Signature of Funeral Service	Licensee										T HOME, INC. CYLAND 20785
Physician	2	3a. Part I. Enter the disease, o		aused the death									Approximate Interval
/Medical	Ì,	failure, List oply one cause mmediate Cause (Final disease		ac Arry	thmia								Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a					•					
ā		Sequentially list conditions, fany, leading to immediate	b. Due to (or as a	consequence o	ıf):								
ted nsit Examine	i	cause. Enter Underlying Cause Disease or injury that initiated	c. Due to (or as a		Α.								
nted id ansit	ľ	events resulting in death) Last	d.	consequence o	11).								
be executed sician and unial - transit		X UNPENDED	AMENDED	23a,27	per m	e g912	2-1	1-11	vt				
760 icate b i physic the bu	23	F FEMALE: Bb. Was decedent pregnant in t	ha -	outcome of preg	. —]e :				ate of deliv	
K 68 1 certif ending use as		past 12 months?	LI CIVE DI	irth ant at time of de		Fetal death Other <i>(Specil</i>	3 <u> </u>	Ectopic p	regnan	СУ	Mo	nth	Day Year
). Box 68760 the death certificate to the attending physiched for use as the by Physician/Me	Ľ		known 9 Unkno										
Division of Vital Records, P.O. Box 68760 To the Hospital or Arending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the buelical Certification: To Be Completed by Physician/Me		art II. Other significant condi	tions contributing to	death but not re	esulting in the	e underlying o	ause giv	en in Part	1.				to the cause of death?
ds, lequires een sig									_	24a. Was	an		autopsy findings available
Records, The law requires frate has been sig rage 2 should be					<u> </u>				_		ormed?	death	
The The Co. page or, page Co.		5. Was case referred to medica	al I			26	.Place o	f Death (C	heck or	1 Yes	2 No	1 🗸	Yes 2 No
Vital ysician this cert directo	1	examiner?	Hospital: 1 Ir	npatient 2	ER/Outpatie	ent 3 DO	A O	ther ₄ _ N	Nursing	Home 5	Residence	6 7 Ot	her: Scene
ing Ph After t funeral		7. Manner of Death 1 X Natural 5 Per		of Injury Day,Year)	28b. Time o			at Work?		8d. Describe	how injury o	occurred	
Sior Mtend death. cctor: by the f			stigation	-61-1				s 2 N		O()	/Out - 1		
Division o spiral or Attending nours after death. neral Director: After filled in by the func Certification:		dete	Id not be 28e, Place rmined (Specify)	of Injury - At ho	ome, farm, st	reet, factory, o	mice bui	laing, etc.		or Town,		Number or	Rural Route Number, City
		4 Homicide 9a. Certifier 1 Certifying P	hysician: To the best	of my knowled	ge, death occ	curred at the t	me, date	and place	e, and d	ue to the cau	ise(s) and m	anner as s	tated.
Division of Vital Records, To the Hospital or Attending Physician: The law requi- within 24 hours after death. To the Funeral Director: After this certificate has been a completely filled in by the funeral director, page 2 should Medical Certification: To Be Complete	ď		miner: On the basis o	f examination a									
F 2 F 3	2	9b. Signature and the of certifi		1200	U		License						Month, Day, Year)
		Oule Sal	le Jell		00.1		O.C.M	.⊏.			Decem	1ber 2, 2	.010
U	3	Name and address of persor Victor Weedn MD JD	who completed caus Assistant Med			Penn Stre	et, Ba	Itimore,	MD 2	1201			
State	3	Date filed (Month, Day, Year)		gis ar's Signatu									
Registra	7	nfc n 9 2010	(Breeze	13. 19									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State	of Ma	arylan		artmen tificate			and N	fental Hy	gien	ne		
			Decedent's Name (First, M.)	iddle, La	st)			<u> </u>	incatt	OI L	<i>Jeann</i>		2. Date of De	Reg. N	No. 2 ()	10	3. Time of Death
	Physicia Medic		Debra Louise		Battle							I	Month Ovenber	25,	2010	Year	9:05 p M
	Examin	ier	4a. Facility Name (if not institu				_		4b. City,	Town, or	Location of			\neg	4c. County o	of Death	
-	Funeral	-	5904 Cherrywood 5. Social Security Number	1 Ten				ast birthday)	If Under		nbelt If Under	24 Hrs	a Data of Di		Prince		
	Director		578-82-6424	1	□ M 2 X F	49		Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da May 8 1	y, Year)	Count	place (State or Foreign try)
	nd now st	١	Usual Residence of Decedent 10a. State 10b. Co.				100 Cit	y, Town or Loc	atio				Cheż O T	201		D.C.	
	larylar 3a-f sl	ecto		,	onge's			eenbelt	alion							11	0d. Inside City Limits 1 Yes 2 □ No
	the M	۱	10e. Street and Number						10f. Zip	Code				100.0	Citizen of W	hat Count	
	s 23a	Funeral Director	5904 Chenrywood	Terr	ace, Apt.	# 20	3		20	770				rog. c	U.S.	nat ooun	uy:
-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	출	11. Marital Status 1X Never Married 2 3 Widowed 4 Divo	ced	12. Was Dece Armed Fo 1 Yes If Yes, Giv Year or D	orces? 2 X /e		1	Yes, spec	ily Cubar 2 X No	Specify:	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)		14. Race Black Africa Specify:		
21215	vithin 72 h iiene. ir than "na ir the Medic	Completed	(Specify only h Elementary/Seconday (0-1	ighest gr	ducation ade completed College (1		+)	16a. Decede (Give k life. DC Clerk	ind of wor NOT use	k done di	ition uring most	of workir	ng		Kind of Bus		lustry
Maryland 21215-0036	should be filed v n and Mental Hyg 7 is marked othe raumatic event,	To Be	17. Father's Name (First, Midd John Sydney Bat		I		·						(First, Middle,	Maidei		10	
, Man	nd 2 should ealth and N m 27 is me ier trauma		19a. Informant's Name/Relati Winter G. Joffrie				_	19b. Mailing	Address Partri	(Street a	nd Numbe ane A	r or Rural Llant a	Route Numbe	r, City o	or Town, Sta	nte, Zip Co	ode)
Baltimore,	permit. Page 1 ar Department of He Important: If iter any injury or oth		20a. Method of Disposition 1 X Burial 2 □ Cremat 4 □ Donation 5 □ Oth	ion 3 [Removal from	State	06	lace of Disposemetery, cremo	ition (Nam atory or ot	e of	3)		ate	20c. l	Location - C	-	wn, State
Ball	permit Depart Import any inj		21. Signature of Emeral Servi	2/11	Tole	2		Bo	mette	& A		Funera		2504			E, WDC 20018
			23a. Part 1. Enter the disease shock, or heart failure. L Immediate Cause (Final	, or com ist only o	plications that one cause on ea	aused to	the death	. Do not enter	the mode	of dying	, such as c	ardiac or	respiratory an	rest,			Approximate Interval Between
	hy sicia n/∹ ∕ Medical		disease or condition resulting in death)				consequ	Lymp!	homa								Onset and Death
	Examiner		Constant like the second					ficie	ncv	Syne	drom	Α.					İ
=	n #	ine	Sequentially list conditions, if all y, leading to immediate cause. Enter Underlying	"	D. Due to (or as a	Consequ	anca of).		7111	ar Om						
	icate be executed g physician and s the burial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	7	C. Due to	or 20 0	conseque										
2	be ex sician burial	edical	Tooding W deathy East	L		OI as a	conseque	erice oi).									
2/60	certificate be executed nding physician and use as the burial-transii	Medi	IF FEMALE:	_	d												
. Box 68	v requires that the death certific been signed by the attending I should be detached for use as		23b. Was decedent pregnant in the past 12 months? 1 Yes		23c. If yes, out 1 Live 4 Preg 9 Unkn	Birth 2 nant at t	☐ Fetal	death 3	Ectopic pr Other (spe	egnancy cify)					23d. Date Monti		y Day Year
J	that t ned b e deta	by P	Part II. Other significant cond	litions co	ontributing to de	eath but	t not resu	Iting in the und	derlying ca	use give	n in Part I.		23e. Did to	bacco	use contrib	ute to the	cause of death?
ds,	quires en sig ould b		Chronic_	Rena	al Fai	lur	е						101	es 2	. □ No 3	☐ Proba	ably 4🏋 Unknown
Vital Records,	law re nas be	Completed	····										24a. Was a		24b. We	re autops	sy findings available pletion of cause of
ğ H	sician: The law a certificate has k irector, page 2 s		25.11										_ perfor		dea	th? Yes 2	
/Ita	s certil	To Be	25. Was case referred to media examiner? 1 ☐ Yes 2 X No		Hospital:					1.0	e of Death						
0	ter this		27. Manner of Death		28a. Date of		12	R/Outpatient 28b. Time of		c. Iniury a	4 LJ Nur		ne 5 🔀 Resid			Specify)	
VISION	tendir leath. tor: Af the fu	Certificate:	1 X Natural 5 Per 2 Accident Inve 3 Suicide 6 Cou	stigation		ri, Day,	rear)	injury	М	work?	es 2 🗆 N	40		•			
	al or At s after o			rmined	28e. Place	of Injury ig, etc. (- At hon (Specify)	ne, farm, stree	t, factory, o	office		28	8f. Location (St City or Town			or Rural R	oute Number,
	To the hospital or Attending Physician: The law requires that the death thin 24 hours after death. To thin Exhours after death. To thin Exhours after death. Completed filled in by the funeral director, page 2 should be detached for the funeral director.	Medical	(Ollock 2 L. Medica		ician: To the be ner: Dn the basi e Practioner: 1	S OT EXA	mination :	and/or investig	ation in my	/ opinion	doath oog	i i was of out the	no Airen	-1 1 ·			4.4 4
	Nith vith com		29b. Signature and title of certi	fier			`			icense n					te signed (A		
		-	Mouetr	(C)	w	12.	ω			D2	371	t3		17	2-1-	10	
	3		30. Name and address of personal Marketin (1) and silver (Month, Day, Year	2/1	27.	52	56	reen	uai	10	fr.	DR	Gre	en	belt	M	D 20770
	State Registra		DEC 0 1 2010	De.	32. Re	grar's	Signatu		(J							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 29d, per State of Maryland/Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 28, 2010 09:51 November Jimmie L. Barnes /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George Fort Washington Fort Washington Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔀 F Georgia July 27, 1933 Director 255-44-2459 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland be partment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" any injury or other traumatic exercises. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1⊠Yes 2□No Director Maryland Prince George Fort Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20744 United States 2809 Capri Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 Never Married 2 Married African 1 ☐ Yes 2 ANO Specify: ģ 3 ☐ Widowed 4 ☐ Divorced American Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Doctor's Assistant Private 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel Swift James Foster Sr. ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2809 Capri Drive Fort Washington, Md. Jeremiah Barnes - Husband Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition December 4, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Washington National 2010 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility oture of Funeral Sorvice Lic Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death VISEase Immediate Cause (Final Atheroscleratic Loronar **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of). physician at the burial Box 68760 Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months?
1 ☐ Yes 2 🗖 No 5 Other (specify) P.O. I 9 I Unknown þ s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, A Q pertension 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Mellitus 24b. Were autopsy findings available prior to completion of cause of death? Diabetes 24a. Was an autopsy performed? 1 □ Yes 2 🗖 No certificate has page 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 THomicide 10 Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 28,2010 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11711 UVINGSTON RD. FORT WASHINGTON MD SACHDEVA MD 31. Date filed (Month, Day, Year) **DEC 0 1 2010**

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Marylan		artment of tificate of	Health and	Mental Hy	211	10 39407
			Registrar 1. Decedent's Name (First, Middle	Last)		Cer	lineate of	Death	2. Date of De	Reg. No.	3 Time of Death
	Physicia		Anita Marie Ca						November 1		2010 12:00 Nooth
-	Medic Examin		4a. Facility Name (if not institution,		mber)		4b. City, Town, o	or Location of Deatl		4c. County	of Death
			Kline Hospice H	louse			Mt. Air	ry		Frede	rick
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🕱 F	7. Age (In yrs. Ia 53	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th 2, Yea <i>r)</i> 1957	g. Birthplace (State or Foreign Country) Washington, D.C
	Director		217-70-5914 Usual Residence of Decedent		23	Yrs,			June	12, 195/	washington, D.C
	at at	ō	10a. State 10b. County		10c, Cit	y, Town or Loc	cation				10d. Inside City Limits
`	Maryla 8a-f: tified	rect	Maryland Fred	lerick	Fr	ederic	k				1 ^{XX} Yes 2 □ No
	the l	۵	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Country?
	h with	Funeral Director	423 Carrollton				2170			USA	
	r iten iner r	/ Fu	11. Marital Status1 ☐ Never Married 2 ☐ Marr	Armed F	edent Ever in U.S orces? 2 🔀 No	5. 13. V	Vas Decedent of I Yes, specify Cub	Hispanic Orlgin? (Sp an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		e - American Indian, ck, White, etc.
20	s afte al", c Exam	d by	3 ☐ Widowed 4 🛣 Divorced	If Yes, Gi	ve	1	☐ Yes 2 1 No	Specify:		Specify	white
5	hour natur dical	Completed		nt's Education est grade completed	۷)	16a. Deced	ent's Usual Occu	pation during most of wor	rking	16b. Kind of B	usiness Industry
7	nin 72 ne. .han " e Me	m o	Elementary/Seconday (0-12)	T	1-4 or 5+)	life. DO	O NOT use retired)	King	OW	n home
7	d with	Be C	17. Father's Name (First, Middle, L	act)		Homem	lakei	19 Mothor's Na	ma (Eirst Middle	, Maiden Surnam	
au	be file sintal H ked o c eve	10	Charles James					Dar1e		, Maiden Gumann	7
3	should be filed within 72 hours after death with the Maryland and Memtal Hygiene. and Memtal Hygiene is marked other than "natural", or items 23a or 28a-f sho is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationsh			19b. Mailin	g Address (Street	t and Number or Ru	ral Route Numbe	er, City or Town, S	State, Zip Code)
Z Z	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Michael S. Camp	bell, Jr	son	5268	Freter I	Road, Syk	esville	, Maryla	nd 21784
ore	of He		20a. Method of Disposition 1 Burial 2 X Cremation	3 ☐ Bemoval from			sition (Name of natory or other pla	ace)	Date		- City or Town, State
Ē	. Page tment tant: I jury o		4 Donation 5 Other (S	specify)	Sta		Cremato	7	-2010	Frederi	ck, Maryland
baitimoi	permit. Page 1 a Department of I Important: If ite any injury or ot		21. Signature of Funeral Service L	ioensee	100		. Name and Addr			r Funera	
		./	23a. Part 1. Enter the disease, or	complications that	caused the deat						Maryland 21702
	nysician/		shock, or heart failure. List of Immediate Cause (Final	only one cause on e	each line.		11	1			Interval Between Onset and Drath
	Medical		disease or condition resulting in death)	a. Due to	(or as a consequ	uence of):	Maystol	Ø/			seconds
	Examiner	L	Se uentially list conditions,	b			Hyp	onhea	Huponi	7	minutes
_	n #	nine	if any, leading to immediate cause. Enter Underlying	Due to	o (or as a consequ	uence ot):	//		11 18		7
	ecuter and -trans	xan	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to	(or as a consequ	uence of):	E	ncephul	t per this	-	days
	ate be executed physician and the burial-transit	dical Examiner					Nan	reasis to	er main	control	weeks
2/00	ficate g phy: as the	Medi	Is service.						7 - 121		
χ οα x	endin r use	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		utcome of pregna	al death 3	Ectopic pregnar	псу			ate of delivery
200	deatl	Completed by Physician/Me	1 Yes 2 No	4 ☐ Pre g ☐ Unl	gnant at time of a known	death 5	Other (specify)			IVIO	onth Day Year
J	at the ed by 1 detach	/ Ph	Part II. Other significant condition						23e. Did	tobacco use cont	tribute to the cause of death?
S,	ires th	d b	Me	tastati	c Cano	er.	Von In	all Cell	1 🗆	Yes 2 No	3 Probably 4 Unknown
<u> </u>	v requ	plete				,	lima	Cancer	24a. Was		Were autopsy findings available prior to completion of cause of
ဒ္ဓ	he lav tte has vage 2	mo							auto perf	ormed?	death? 1 Yes 2 No
<u>.</u>	ian: T ertifica ctor, p	Be C	25. Was case referred to medical examiner?	7/10				Place of Death (Che	eck only one)		
=	hysic this ce al dire	은	1 Ves 2 No		Inpatient 2		t 3 L DOA				ner (Specify) Kline House
0	ding F h. After funera	ate	1 Natural 5 ☐ Pendir	ng (Mo	e of injury nth, Day, Year)	28b. Time of injury	wo		28d. Describe	how injury occur	ed
Division of Vital Records,	Atten	Certificate:	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	e of Injury - At ho	ome, farm, stre	eet, factory, office				per or Rural Route Number,
$\frac{2}{5}$	alor, safte al Dire		4 - Homicide determ	build	ding, etc. (Specif)	1)			City or To	wn, State)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit completed filled in by the funeral director.	Medical		Physician: To the	best of my know	ledge, death on and/or invest	occured at the tim	e, date and place,	and due to the c	ause(s) and manr and place, and du	ner as stated. ue to the cause(s) and manner stated.
	thin 2 thin 2 the F	Me		Nurse Practioner	: To the best of m	y knowledge, o	death occurred at t	the time, date and pl	ace, and due to t	he cause(s) and m	anner as stated.
	K 3 K 8		253. Signature and this or out this	Will	Mi	Ď	D	67442		11/	30/2010
			30. Name and address of person	who completed car	use of death (Iten	1 23a) (Type, F	Print)	h 1		444	le to the cause(s) and manner stated. leanner as stated. led (Month, Day, Year) 30 / 2010
	1		/	46B	Thomas	Johns	en Drive	, tre de	rick, I	MR 21	102
	Stat Registra		31. Date filed (Month, Day, Year)	2 20 10 32.	Registrar's Signa	ture .	backer				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GEORGE MARKELL CHAPLINE, JR. Nowember 29, 20 TO 1:15 Pм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Glade Valley Nursing & Rehab. Center Walkersville . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sept. Day 3 9 1 X M 2 🗆 F Months Days (ear) 1921 Mary Tand 577-24-4255 89 Yrs. **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1X Yes 2 ☐ No Walkersville Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 56 West Frederick Street 21.793 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 No Specify. Specify: White 3 X Widowed 4 Divorced WWII Completed Year or Dates Ith and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Agent Insurance æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Clara Kelly George M. Chapline, Sr. permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is mar) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8115 Laurel Ridge Road, Frederick, MD 21702 Tom Trott / Son-in-law item 2 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. John's Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 5 1 XBurial 2 Cremation 3 Removal from State 12/3/2010 Frederick, Maryland injury 4 Donation 5 Other (Specify) 21. Si ... ure of Eugeral Service Lice ROBERT C. DATCEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET STREET, FREDERICK, MD 21701 23a. Part 1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a ch line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician years disease or condition Medical resulting in death) Due to (or as a d nsequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician a hed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 2 No Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ZNo 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy eral Director; After this certificate filled in by the funeral director, pag 2 No ☐ Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: ဂ္ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at 28a. Date of injury Certificate: 28d. Describe how injury occurred (Month, Day, Year) work? Natural Accident iniury 5 Pending Investigation Suicide 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number within 24 hours after To the Funeral Direc determined Hospital 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and some states and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature nd title certifie 29c. License number

State Registrar Month, Day, Year)

no completed cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Channie L. Casey		artment of Health and Mental I rtificate of Death	Hygiene 2 1 1	0 3940
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) CHANNIE LOUISE CAS		Reg. No. 2. Date of Death Month Day Year December 4, 2010	3. Time of Death 0015 hrs
	4a. Facility Name (if not institution, give street and number) University Hospital	4b. City, Town, or Location of Dea Baltimore		ath
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. la 1 M 2 1 F 69	ast birthday) If Under 1 Year If Under 24H Months Days Hours M Months Days Hours M	rs. 8. Date of Birth(MM/DD/YYYY) 9. t in. 07/24/1941	Birthplace (State or eign Country)VTRGINTA
rland -f show any once,	MARYLAND HARFORD	Town or Location ABERDEEN		10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once, al Director	10e. Street and Number 603 PLATER STREET	10f. Zip Code 21 001		STATES
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once :ed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed)	S. 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No specify: 16a. Decedent's Usual Occupation (Give kind of	to Rican, etc.) White, etc.	BLACK
7 - 7	Elementary/Secondary (0-12) College (1-4 or 5+) 5+	during most of working life. DO NOT use re		
21 be fill rked cut,	17. Father's Name (First, Middle, Last) UNKNOWN		ne (First, Middle, Maiden Surname) /IRGINIA HUBBARD	
_ 0 = 0 = 1 = 1	19a. Informant's Name/Relationship (Type, Print) WALLACE CASEY / HUSBAND	19b. Mailing Address (Street and Number or 603 PLATER STREET,	ABERDEEN, MARYLANI	21001
S 5 5 5 5	1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:		Date 20c. Location - City of 2/9/10 DARLING	TON, MD
Baltimo permit. Page permit. Page Department. Important: injury or ott	21. Signature of Funeral Service Licensee 23. Part I. Enter the disease, or complications that caused the death.		'. HAVRE DE GRACE.	MD 21078 Approximate Interval
/Medical. Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Head Injuries Due to (or as a consequence of	f):		Between Onset and Death
aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last			
e executed cian and rial - transit	d. I AMENDED 23a,27,2	28a-f per me g912 2-2-	ll vt	
ox 687 sath certific attending p for use as th	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknown 23c. If yes, outcome of pregnant in the pregnant at time of deal pregnant at time o	2 Fetal death 3 Ectopic pregn	23d. Date of delive Month	ry Day Year
ires that the de signed by the detached is detached the by Phy	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	o the cause of death?
Division of Vital Records, P.O. Into Attending Physician: The law requires that the safter death. al Director. After this certificate has been signed by led in by the funeral director, page 2 should be deach stiffication: To Be Completed by Fartification:			autopsy prior to death? 1 ✓ Yes 2 No 1 ✓ Y	
F Vital Replysician: The rhis certificate al director, page	1 Y res 2 No		ng Home 5 Residence 6 Other	er:
Division of Vital or Attending Phyris after death. rel Director: After the line in by the funeral lifed in by the funeral ertification: T	Natural 5 Pending Investigation Place of Injury - At ho	28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No ome, farm, street, factory, office building, etc.	28d. Describe how injury occurred subject fell 28f. Location (Street and Number or R	ural Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Founcal Director: completely filled in by the ledical Certificatii		d Memorial Hospital pe, death occurred at the time, date and place, and	or Town, State) 501 S. Havre de Grace, M.	
To the Howithin 24 h To the Fur completely	one) 2 Medical Examiner: On the basis of examination an and manner stated 29b. Signature and title of certifier	ad/or investigation, in my opinion, death occurred 29c. License number	at the time, date and place, and due to t	
	30. Name and address of person who completed cause of death (Item)		December 5, 20	110
State	Zabiullah Ali, M.D. Assistant Medical Examiner 31. Date filed (Martin Pay Year) 32. Registrar's Signatur		1201	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Nov TINA LOUISE CAPEL 2010 0657 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital at Earton Facton Toy bot Memorial If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours DCT. 31, Year) 1 □ M 2 🕱 F MARYLAND Director 217-86-6841 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 X No QUEEN ANNE CENTREVILLE MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21617 USA 417 DEAN ROAD hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14 Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White, etc. δ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: 3 Widowed 4 X Divorced Completed WHITE Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) RECEPTIONIST CHILD SUPPORT SERVICES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 LILLIAN GRACE GERNERT THOMAS EDWARD CAPEL, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trau once. 417 DEAN ROAD, CENTREVILLE, MD 21617 of Health JUSTIN RUSSUM/ SON 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign were Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Breast Carcinoma Metastatic Physician/ disease or condition resulting in death) Medical Examiner Thrombocytopenia Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): per natremia the Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical pokalemia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No ò Year Dav Pregnant at time of death Unknown g 🗌 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed certificate 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 🗆 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Direct Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date directioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0069567 Mohan Nov, 29, 2010

Registrar

DHMH 17 Rev 7/2009

State

R.MOHAN, M.D., 219 S. WASHINGTON ST., EASTON, MD 21601

32 Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year

NOV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 10e State of Maryland / Department of Health and Mental Hygiene Registrar WCHD/SH 12/3/10 per FH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 4:55AM Hildegarde Beatrice Carpenter JOVEMBER 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, July 28 If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Days Hours Country) st Virginia 1 □ M 2 🔽 F 94 Director 232-26-6911 1916 |West July Usual Residence of Deceden or 28a-f show 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 227 Winding or items 23a Funeral 10116 Sharpsburg 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ※ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 호 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural" Completed 3 X Widowed 4 Divorced White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within rment of Health and Mental Hygiene. Fant: If item 27 is marked other tha jury or other traumatic event, the I Executive Secretary Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Luther L. Souder Ida Victoria Strawderman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 227 Winding Oak Dr., Hagerstown, MD Carolyn A. Derr/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Rest Haven Cemetery 12/3/2010 4 Donation 5 Other (Specify) Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) RUPTURED Medical Due to (or as a consequence of): Examiner BRIGHSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury attending physician and I for use as the burial-transit ATHEROS CLEROTIC that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 No 2 1 1 Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 🗌 Yes 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) UITE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RITOWN

State

PATELA 31. Date filed (Month)

6

2

11110

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph Cornell Clayton Day NOV. 2010 29 12:10 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Wasn. DC 8. Date of Birth **Funeral** Hours 61 215 52 5585 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City Town or Location 10d. Inside City Limits Director MD St. Mary's 1 X Yes 2 No Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24062 Hollywood Rd. 20636 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates or than "natural", the Medical Exar 1 ☐ Yes 2X No Specify: Specify:Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Landscaper Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, George R. Clayton, Sr. Margaret R. Lawrence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Frances Clayton/ Wife 24062 Hollywood Rd.Hollywood, MD 20636 20b. Place of Disposition (Name of cernetery, crematory or other place)
St. George's Cem. 12/6/2010 Valley Lee, MD 20a. Method of Disposition 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State St. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign up of Funeral Service License 22. Name and Address of FacilitBriscoe-Tonic Funeral Home 2294 Old Washington Rd.Waldorf,MD 20601 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ dicease disease or condition resulting in death) Oronary Medical Due to (or as a consequen of) **Examiner** abetes ears Sequentially list conditions, if any heading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine or Attending Physician: The law requires that the death certificate be executed ears and -trans resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Longestive Heart 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed certificate 2 🗌 No 1 🗌 Yes Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 Natural 2 Accident 5 \square Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amish V.Shah,

24035 Three Notch Rd. Hollywood, MD 20636 M.D.

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RONALD LYNN CROFOOT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death CIVISTA MEDICAL CENTER LA PLATA CHARLES 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 09-12-1948 1XX/12 🗆 Months Hours Min. 219-48-8117 62 Director WASHINGTON, DO Usual Residence of Decedent 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho 10d. Inside City Limits Director MD CHARLES HUGHESVILLE 1 Tes 2XXVo 10e, Street and Number 10f. Zip Code Citizen of What Country? UNITED STATES Funeral 6400 CRACKLINGTOWN ROAD 20637 12. Was Decedent Ever in US 7 Armed Forces? 10 1967 1 X Xes 2 No 1967 1 Yes, Give 0 - 11 - 65 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2XXMarried Maryland 21215-0036 69a 1 ☐ Yes 2XXNo Specify. Specify WHITECompleted 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) PLUMBING (LÓCAL#5) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) MASTER PLUMBER JOSHUA CONTRUCTION 12TH Be 17. Father's Name (First, Middle, Last) .. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked otl jury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ROBERT FAY MONTEEN CROFOOT GUY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONNA L. CROFOOT WIFE 6400 CRACKLINGTOWN RD., HUGHESVILLE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MARYLAND VETERANS CEMETERY DECEMBER 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State CHELTENHAM, Important; If any injury or 02, 2010 4 Donation 5 Other (Specify) 21. Sign have of Funeral Service Lica TERRENCE L. JOHNSON FUNERAL SERVICE 4433 WHITE PLAINS LANE, WHITE PLAINS TERRENCE JOHNSON#M00993 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician andies disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year page 2 should be detached by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2) No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 Yes Other: 2 No 1 Inpatient ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 14Natural 5 Pending work 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: A Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 144 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifier 2025023 address of person who completed cause of death (Item 23a) (Type, Print) 12090 Old LINE

State

Registrar

31. Date filed (Month, Day, Year)

NOV

29 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#5perFH, 12/9/10, EMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 29, 2010 11:00 AM Isidor COHEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3310 N. Leisure World Blvd., #114 Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 X M 2 - F Months Days Hours Ma (Month D 2 1 Year) 1915 95 Massachusetts **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State Director Maryland Silver Spring Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3310 N. Leisure World Blvd., #114 20906 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 🗆 Yes 2 💆 No Specify 3 Divorced 4 Divorced WW II Year or Dates. permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Certified Public Accountant Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Max Cohen Helen Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17052 Briardale Road, Derwood, MD 20855 Ellen Lobel, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Judean Memorial Gardens 12/01/10 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Olney, MD 4 Donation 5 Other (Specify) 21. Signature of Fune al Serve Licensee Torchandskys Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause of Immediate Cause (Final Physician/ disease or condition resulting in death) Medical a consequênce of: Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death. the Funeral Director. After this certificate has been signed by the attending physician and npleted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2- No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27 Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Accident Natural 5 Pending work' 1 Yes 2 | No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Chec only 3 Certifying Nurse Prage oner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sign 29d. Date

State Registrar 31. Date

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year ATTERTER NOV 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sanctuary at Holy Cross Burtonsville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days 64 Nov. 15, 359-50-9777 1946 Índia Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 TXNo MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1316 Fenwick Lane, Apt. 1303 20910 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: Asian Indian 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Professor University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jawahar Lal Chatterjee Bani Mukheriee 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sunil Chatterjee/Brother 804 Stirling Road, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Dec. Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 2010 21. Signatura Funeral Service Licenses Francis ddgss of Tilins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) UNG Due to (or as a consequence of) Sequentially list conditions Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant

Physician: The law requires that the death certificate be executed physician a s the burial-Box 68760, Division of Vital Records, P.O. the hed ģ signed h After this certificate funeral director, pag-Hospital or Attending To the Hospital or Attendi

L within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu death.

Physician

/Medical

Examiner

Director

Funeral

ò

Completed

Be

ဂ္

Physician/Medical

þ

Be Completed

Certification: To

Medical

(Check only

29b. Signature and little of certifier

ASNEEM 31. Date filed (Month, Day, Year)

use

ò

r, page

Funeral

Director

item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Wedical Examiner must be notified at

"natural", or

Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Ins. Ma

Physician

Examiner

/Medical

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unkn <i>o</i> wn		4 🗆	Pregnant at time of Unknown		5 ☐ Other					Month	Day	Year
Part II. Other signific	cant conditions of	ontributir	ng to death but not res	ulting in th	ne underlyin	g caus	se given in	Part I.	23e. Did tobacco	use contribute		
									24a. Was an autopsy performed?	prior to death?	o completion	lings available n of cause of
25. Was case referre	ed to medical						26.	Place of Dea	th (Check only one)		7	
1 Yes 2 1 1	10	Hospita	: 1 ☐ Inpatient 2 ☐] ER/Outpa	atient 3 🗌	DOA	Other:	Nursing H	ome 5 Residence	6 □Other (Sp	pecify)	
27. Man Per of Death Natural □ Accident	5 Pending investigation		. Date of Injury (Month, Day, Year)	28b. Tin Inju		28c.	Injury at Work? 1 ☐ Yes	2 □No	28d. Describe how inju	iry occurred		
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e	Place of Injury - At h building, etc. <i>(Speci</i>	ome, farm fy)	, street, fac	ory, of	fice		28f. Location (Street a City or Town, Sta		Rural Route	Number,
29a. Certifier	Certifying Ph	ysician:	To the best of my kn	owledge, o	leath occur	red at	the time, o	late and place	e, and due to the cause	s) and manner	as stated.	

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

7

30 Name and address of person who completed cause of death (Item 23a) (Type, rint)

Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD Approximate Interval Between Onset and Death 3mm tho 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie R06412 11-29-10 IIIIO Medical Campus Road, Suite 143 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leise ant Hagerstown Maryland 21742 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 01 Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2 U | U

39416

3. Time of Death

5:20

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 X No

Indiana

White

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month OZUM Physician/ Year iamor llen Medical 4b. City, Town, or Location of Death Annapolis 4a. Facility Name (if not institution, give street and number) County of Death
Anne Arundel Examiner Amnc Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2🗓 F Months Hours Min (Month, Day, Year, 23. Missouri 488-22-2566 Director 1926 Usual Residence of Decedent 28a-f shov 10b. County should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho aţ 10a, State 10c. City. Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified MD Crofton Anne Arundel 1 Yes 2 No 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 21114 USA 1498 Lowell Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Examiner Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3 ☒ Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) event, the Budget Analyst Aerospace Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be a Department of Health and Mental Important: If item 27 is meany injury or other. ည Louise Sanford Ezra H. Cannady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1439 Crofton Pkwy., Crofton, MD Herbert J. Diamond 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Metro Crematory 11/20/2010 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature 22. Name and Address of Facility of funeral Service Licenses Beall Funeral Home 6512 NW Crain Hwy. Bowie, 20715 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsel and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown this certificate has been signed by the atteral director, page 2 should be detached for Month Dav Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 X No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 💢 No 2 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? death. 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific round Berly D46052 30. Name and address of person who completed cause of death (Item 23a), (Type, Print) a kwy Sived Bey TW 200, Medical Pakwy

State Registrar

DHMH 17 Rev 7/2009

Siveral Beck, MUD

31. Date filed (Month, Day, Year) NOV 2 2 2010

back

2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend Item 25 per me,g910,12/17/2010dhb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 20 Physician/ Margaret H. Dakin 2010 10:21 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Yes Aug. 10, Social Security Number . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Hours Year) 179-16-0950 88 1922 Pennsylvania Director Aug. Usual Residence of Decedent items 23a or 28a-f shov ner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Annapolis Anne Arundel Maryland 1 XYes 2 No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? U.S.A. 21403 Funeral 700 Americana Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status ral", or iter Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: "natural". **¾**Widowed 4 □ Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) . Page 1 and 2 should be filed within 73 treent of Health and Mental Hygiene. tant: If item 27 is marked other than jury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Medical Secretary Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew Hullow Eva Manzak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Dakin Campbell/daughter 21403 1326 Blackwalnut Court Annapolis, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore Crematory 11/22/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M./Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car liac or respir tory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Intracranial hemorrhage Physician days disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ROVER BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): sician and burial-transit The law requires that the death certificate be executed Cause (Disease or linjury CERTIFICATION APP that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical 68760 as the IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery Box Live Birth 2 Fetal death 3 Ectopic pregnancy þ in the past 12 months?
1 Yes 2 No Year Day Pregnant at time of death 5 Other (specify) the detached O signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? σ. Completed by page 2 should be Records, 1 Yes 2 No 3 Probably 4XXUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2 No 1 ☐ Yes 2XX No within 24 hours a er death.

To the Funeral Director: After this certified completed filled in by the funeral director, I Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ot 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No 28b. Time of Certificate: 28d. Describe how injury occurred or Attending 1XXNatural 5 Pending Division 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D35494 November 20, 2010

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

2001 Medical Parkway Annapolis, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Steven Resnick,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 201. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 6:09 P M November Miriam J. Dredger Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel <u>Anne Arundel Medical Center</u> ${\tt Annapolis}$ g. Birthplace (State or Foreign Country New York 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number **Funeral** 1 □ M 2 ⋤ F Months Davs Hours 0172371928 082-20-4564 82 **Director** Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10b. County 10c. City, Town or Location 0a. State Director 1 🗆 Yes 2 🎦 No Edgewater notified Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number pe Funeral 23a 3913 West Shore Drive 21037 United States **Examiner must** death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedon:
Armed Forces?

¹ ☐ Yes 2 ⚠ No Black, White, etc. 2 should be filed within 72 hours after d tth and Mental Hygiene. 27 is marked other than "natural", or i traumatic event, the Medical Examin. 1 ☐ Never Married 2 X Married by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Michael Bamonte Loretta Twohey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3913 West Shore Drive, Edgewater, Maryland 21037 19a. Informant's Name/Relationship (Type, Print) Robert F. Dredger, Sr./Husband permit. Page 1 and 2 sl
Department of Health a
Important: If item 27 is
any injury or other tra 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or othe 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery 12/30/2010 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signat Me MD 21037 2973 Solomons Island Rd. Edgewater, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respishock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Subdural Hematoma disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami -tran and Due to (or as a consequence of) resulting in death) Last ng physician ar as the burial-t Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 👿 No 3 □ Probably 4 □ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA ၉ 28d. Describe how injury occurred Subject fell 28b. Time of 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural
2 X Accident injury 5 Pending walking to the bathroom. 12:15 P ^M 11/15/2010 Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)
2001 Medical Donner Pavillion Office Building Pkwy.Annapolis,M Medical Scertifying Physician: To the best of my yowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Ination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of exa (Check Certifying Nurse Practioner: To the b 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a 2010 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 50 31, Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

NOV 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar #7&8, per funeral home, Certificate of Death D.H., WCHDReg. No. U Amended item 2. Date of Death Month Dat 11/29/2010 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:01 A M Andrea Judith Dimitri /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Worcester

8. Date of Birth 2/3/194 5. Birthplace (State or Foreign (Month, Day, Year)

2/3/19/18

MD Snow Hill 4835 Scotty Road If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday, 6. Sex 5. Social Security Number **Funeral** 63 -62 1 ☐ M 2 🔀 F Yrs. Director 220-50-1926 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County r 28a-f show notified at 1 ☐ Yes 2☐ No Snow Hill MD Worcester the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a USA 21863 4835 Scotty Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 and 2 should be filed within 72 hours after. Health and Mental Hygiene. em 27 Is marked other than "natural", or ite Specify: White 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No altimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sylvia Katherine Erdbrink Andrew Jacob Semenkiw 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 Is
any injury or other trau 108 Kenilworth Park Drive, Towson, MD 21204 Ted Talbert/Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 12/1/2010 Millsboro, DE First State Crem. 4 □ Donation 5 □ other (Specify)

21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 23a. Part 1. Interthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metustut. Chelange carcine use. 108 William St., Berlin, MD 21811 Approximate Interval Between Onset and Death 2 months Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IE FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the sid be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1☐ Yes 2 1 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 1 Matural 5 Pending investigation To the Hospital or within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

77.7 State Registrar

29b. Signature and title of certifier

Clybe Ennest Gibb JR M.) 31. Date filed (Month, Day, Year)

20063253

29c. License number

11.30-10

29d. Date signed (Month, Day, Year)

C. Ernest Collets of No. 3.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

428 WestmarketSt SmwH,11 m221863

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Barbara Duncan 26 2:06 pM NOV 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) Months Days Hours Min 1 M 2 xF **Director** 32-34-8349 74 Dot 18, 1936 Germany Usual Residence of Decedent or 28a-f show 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Rockville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4602 Bayne Court 20853 Germany 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🙀 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married Married 1 Yes 2 No Specify: Specify: White Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 at Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Medical Lab Technician permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental ? is marked o Friedrich Gerhart Hildeaguard Kommnick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4602 Bayne Ct., Rockville, MD 20853 Edward Duncan/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State No \mathbf{v} . Page 1 26 metery, crematory or other place) 1 Durial 2 K Cremation 3 Removal from State etropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 2010 21. Signature of Funeral Service Liousee Name and Address of Facility rancis J. Collins Funeral Home O University Blvd. W., Silver e Inc. Spring,MD 23a. Putal. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ Brain Tumor disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) burial-transit Cause (Disease or iinjury death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Year ned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed l 23e. Did tobacco use contribute to the cause of death? þ Acute Stroke Completed 1 Tyes 2 No 3 Probably 4 1 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an this certificate 1 Yes 2 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 XNo Other: ဂ္ x Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No neral Director: A М hours after death Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital
within 24 hours a
To the Funeral C

Registrar

State

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

29a. Certifier

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Medical

2. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Irina Ruban, MD 1500 Forest Glen Road, Silver Spring, MD 20910

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D63343

29d. Date signed (Month, Day, Year)

2010

Nov. 26,

29c. License number

amended item number 18/wchd/map/12-01-2010 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_ FOI	ite of Maryland / D			ental Hygie	ne	
		State Registrar		Certificate of	Death	Reg.	No.	201,22
Physici /Medio		1. Decedent's Name (First, Middle, Last) RUDOLPH Macual	LEN DOSHIE	ic SR		2. Date of Death Month	Day Year 3010	3. Time of Death
Examin		4a. Facility Name (If not institution, give street	and number)	4b. City, Town,	or Location of Death		4c. County of Death	
		5. Social Security Number 6. Sex	7. Age (In yrs. last birti	hdav) If Under 1 Year	SBUCY If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
Funeral Director	į.	214-36-5702 12M 2		rs. Months Days	Hours Min.	(Month, Day, Ye. 5 - 19 - 1	ar) Cou	omito GUNTS
pu		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
// Aarylan f show ed at	ō	md Wiscomic		ISBURY				1 □Yes 25 No
r 28a- notifi	Director	10e. Street and Number	JAZ	10f. Zip Code		10g.	Citizen of What Cou	intry?
th with 23a o Ist be	al D	409 Donsey LAN	$v\epsilon$	218	301		USA	
er dea tems ter mu	Funeral	Ari	as Decedent Ever in U.S. med Forces?	13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Spe ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
irs afte	by F	If Y	⊒Yes 2∰ No Yes, Give ear or Dates:	1 □ Yes 2 No	Specify:		Specify: RL	ACT
be filed within 72 hours after death with the Maryle that Hygiene. And Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted	15. Decedent's Education (Specify only highest grade comp	nleted) 16a.	Decedent's Usual Occu (Give kind of work done	pation	na 16b	. Kind of Business/Ir	ndustry
ne. han "	Completed		ollege (1-4or 5+)	(Give kind of work done life. DO NOT use retire	DRIVER		7011-1-	,,_
filed v Hygie ther t		17. Father's Name (First, Middle, Last)		nuck L	1		IRUCKI den Surname) Wa	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	To Be	CONWAY WENDEL	DASATECL		mark	-TANE	DASK:	Elle
2 shou and N is mai	_	19a. Informant's Name/Relationship (Type. Pr.		Mailing Address (Stree	t and Number or Rura	al Route Number, Ci	ty or Town, State, Zi	p Code)
t and 2 should f Health and Mer item 27 is marke other traumatic		BERNICE COURNS		Disposition (Name of		SACESSAC Date 20c	108, MD	21801
permit. Pages 1 and Department of Health Important: If item 27 any injury or other tronce.		20a. Method of Disposition 1	al from State cemeter	Disposition (Name of y, crematory or other pla	ace)		Location - City or T	own, State
nit. Partme		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Spra	2058.// 22. Name and Addr		27-2010	NEBROW	IND
permit. Departri Importa any inju		* Kell R Kken	- (ESP	STECULAT	FURRAL !	Home 82	I WAST RE	Sulstang, or
		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	se on each line.					Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		atic Bl	adder	CANCER	2	Oriset and Death
Examiner			Due to (or as a consequence o	of):				
\$ & B	ner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due to (or as a consequence of	of):				
be executed total and burial-transit	Examiner		B - 4- /					
cate be executed physician and the burial-transit			Due to (or as a consequence o	n).				
ifficate g phys	edical	d						
leath certific attending p	an/M	23D. Was decedent pregnant	yes, outcome pf pregnancy □Live birth 2 □ Fetal death	3 ☐Ectopic pregnance	су		23d. Date of deliv	4
The law requires that the death certificate ite has been signed by the attending physoage 2 should be detached for use as the	Physician/Me		□Pregnant at time of death □Unknown	5 Other (specify)			Month	Day Year
w requires that the de been signed by the should be detached		Part II. Other significant conditions contributi	ng to death but not resulting in	the underlying cause gi	iven in Part I.	23e. Did tobaco	co use contribute to	the cause of death?
requires	ed by			******		1 ☐ Yes	2 No 3 Pro	obably 4 Unknown
faw re as bee 2 sho	Completed					24a. Was an autopsy	24b. Were aut	topsy findings available ompletion of cause of
The cate h	Com					performed 1 Yes 2 12	death?	
sician certifi rector	Be	25. Was case referred to medical examiner?	al:	Ot	her:	(Check only one)		
g Physer this eral di	T0:			ime of 28c. Inju	4 LI Nursing Ho	me 5 La Residence 28d. Describe how i	e 6 □Other (Specinjury occurred	ify)
ath. or: Afte	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) In		Yes 2 No			
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 286	 Place of injury - At home, far building, etc. (Specify) 	rm, street, factory, office)	28f. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
spltai ours a neral D		29a. Certifier 1 ☐ Certifying Physician	: To the best of my knowledge	, death occurred at the	time, date and place,	and due to the caus	e(s) and manner as	stated.
ne Hoo n 24 h ne Fur bletely	Medical	(Check only 2 Medical Examiner: C	on the basis of examination and manner stated.					
To the within To the comp	Me	29b. Signature and title of certifier	Oder	29c. Licen	ise number	29d.	Date signed (Month	n, Day, Year)
Gul		Doual pshe	N PIC	C00	03444		11/23/2	010
AMI		30 Name and address of person who complete	ed cause of death (Item 23a) (Type Print) I Ford Str	eft Sint	103 Sa	lishury	MD 21814
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1 HOLU OIL	u jui	100 Ju	110000	
Registi	rar	NOV 29 2010	Deneur B.	park				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 28. 2010 0735 M JEAN FISHER EBLING Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** DEC. 7, 1934 Hours 1 □ M 2 🕱 F MARYLAND Director 75 220-32-7521 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No MD QUEEN ANNE STEVENSVILLE 10e. Street and Number 10g, Citizen of What Country? Funeral 21666 USA 2208 ROMANCOKE ROAD . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give WHITE 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည EDITH ELLA HOLDEN WILMER LOUIS SPARKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2208 ROMANCOKE ROAD, STEVENSVILLE, MD 21666 GEORGE ALDEN EBLING/HUSBAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ■ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) DEC. 1, CHESTERFIELD CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) CENTREVILLE, MD 2010 Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 408 S. LIBERTY ST., CENTREVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ 4 iluna disease or condition Medical resulting in death) Examiner weeks Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or). or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit 100 Kalen that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth
4 Pregnant
9 Unknown 3 Ectopic pregnancy in the past 12 months 1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPD 2 No 3 ☐ Probably 4 ☐ Unknown SUT 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 completed filled in by the funeral director, page 2. death? Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2 No 잍 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury unatural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

Registrar

State

Ridgely

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

00

32.,Registrar's Signature

4007048L

		1 - For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Mar	-	epartmer Certificat			2. Date of Dea	eg. No.	3 9 4 2 4
Physici			le M. Edwa	rde				Novembe	r 24, 20	10 15:32 N
/Medic Examin	-	4a. Facility Name (If not institution, give s		ilus	4b. City	Town, or	Location of D		4c. County of	
Lxamiii	٠,	Gladys Spellman	Nursing H	lome		Che	verly		Prin	nce George
Funeral Director		5/9-28-/004	7. Age	(In yrs. last birthd 96 Yrs	Months	Days	Hours N	Hrs. 8. Date of Birth Min. (Month, Day April 1.	Year) 3, 1914	Birthplace (State or Foreig Country) Maryland
death with the Maryland ms 23a or 28a-f show rmat be notified at	Director	Usual Residence of Decedent 10a. State 10b. County DC		10c. City, Town o	r Location		Washi	ngton		10d. Inside City Limits 1 X Yes 2 ☐ No
ith th	Dire	10e. Street and Number			10f. Zi	p Code			0g. Citizen of Wh	at Country?
ath w 8 23a		101 56th Street				4.0	2001			ed States American Indian.
after or Ite	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 3	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	ver in U.S.		ecify Cubar 22 No		? (Specify Yes or No- luerto Rican, etc.)	Black, Specify:	White, etc. African
in 72 hours 1 "natural", o	Completed t	15. Decedent's Educ (Specify only highest grade	cation e completed)	(C	ecedent's Usu Give kind of wi	ial Occupa ork done d ise retired)	tion uring most of	working	16b. Kind of Busi	American ness/Industry
within liene. r than "	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	Food	Servi	.ce (Ba	aker)	DC Go	overnment
filled Hyg other	0	17. Father's Name (First, Middle, Last)					-	Name (First, Middle,		
	To B	Wi1	liam Harr:	is				01ivia	Booker	
s 1 and 2 should f Health and Mer item 27 Is marke other traumatic	-	19a. Informant's Name/Relationship (Type	pe, Print)	19b. M	lailing Addres	s (Street a	nd Number o	or Rural Route Numbe	r, City or Town, St	ate, Zip Code)
and 2 alth a		Benjamin W. Edwards	s - Son	110	005 Biı	ch W	ay Cl	inton, Mar		
00-1		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ R	amount from State	20b. Place of D cemetery,	isposition (Na crematory or	me of other place	Dec	cember 3,	20c. Location - C	ity or Town, State
nit. Pages artment of ortant: If it Injury or o		4 □ Donation 5 □ Other (Specify)	emoval from State	Maryla	nd Nat:	ional		010	Laurel,	Maryland
permit. Page Department of Important: If any Injury of		21. Signature of Funeral Service License	9	~ AMI	22. Name a	ind Addres		Stewart F		
Depti Impo		Mound	1010v	COLD IN	#001 H	enni	ng Roa		ington,	E 4 4 4 4 1
Physician		23a. Part1. Enter the disease, or o mpli shock, wheart failure. List only or Immediate Cause (Final disease or condition	cations that caused the cause on each line					rdiac or respiratory ari	est,	Approximate Interval Between Onset and Death 48 HKS
/Medical Examiner		resulting in death)		consequence of)						48 HRS
eath certificate be executed attending physician and for use as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of) consequence of)	GKES	WIT	H /N	RACRANIAL	HEMORI	RHAGE BYR:
the d y the ched	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	☐ Fetal death	3 □Ectopic p				23d. Date Mont	,
w requires that been signed by should be deta	þ	Part II. Other significant conditions con	ntributing to death but	not resulting in th	ne underlying	cause give	n in Part I.			oute to the cause of death?
The law ate has b page 2 s	Completed							24a. Was autop perfor	sy pri med? de	ere autopsy findings availab or to completion of cause of ath?] Yes 2 [] No
Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	losnital:			100		Death Check only o	ne)	
hys this	2	Tes ZINO		t 2 ER/Outp			4 140131	ng Home 5 Resid		
ding After fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day	Yea <i>r)</i> Inju	Iry M		at :? ∕es 2 □ No		ow injury occurred	
or A lifter or by		4 Homicide determined	28e. Place of Injur building, etc.	(Specify)				City or Tow	n, State)	or Rural Route Number,
he Hospitel in 24 hours a he Funeral i pletely filled	edical	(Check only 2 Medical Examination)	sician: To the best of ner: On the basis of e and manner state	examination and/	or investigation	n, in my or	oinion, death	place, and due to the occurred at the time,	date and place, ar	id due to the cause(s)
To the within 2 To the complete	Σ	29b. Signature and title of certifier	elle	ush	7		213		77/.	(Month, Day, Year) H(1).
4		30. Name and address of person who or REVATHY MURTH)	ampleted cause of dec	ath (Item 23a) (T)	ype, Print) SPITAL	DR	NE	CHEVER	H, MD	20185
Sta Regist		31. Data filed (Month, 2010 ar)	32. Registrar	"S STATE						

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Leg	gible.	0.01.07
State of Maryland / Department of Health and Mental Hygiene	2010	3942
0 45 4 55 4		

	1- For State Registrar		Certif	icate of	Death			Reg	. No.	
Physician/ Medical Examiner	1. Decedent's Name (First, Middl Timothy	K.	E	ngland				Date of Death Month December	Day Yea 4, 2010	3. Time of Death 1024 hrs
	4a. Facility Name (if not institution 221 Baltimore Avenue		nber)	41	c. City, Town, or I Cumberland		Death		4c. County of Allegany	
Funeral Director	5. Social Security Number 217-88-6313	6. Sex 7	'. Age (In yrs. last I	birthday) Yrs.	If Under 1 Year Months Days		24Hrs. 8 Min.	B. Date of Birth May 24		Birthplace (State or Foreign Country)
and show any ncc.	Usual Residence of Decedent 10a. State 10b. County MD A	llegany	10c. City, To		berland					10d. Inside City Limits 1 X Yes 2 No
eath with the Maryland items 23s or 28s-f sho ust be notified at once uneral Director	10e. Street and Number 814 Stewart				10f. Zip Code	215	02	100	j. Citizen of Wh	at Country? USA
Ferd F	3 Widowed 4 Div	arried Armed Ford 1 Yes orced If Yes, Give Year or Dates:	2 ☐ No	If Ye	Decedent of Hisps, specify Cuban, Yes 2 No Substitute 1 Usual Occupation	Mexican, P specify: on (Give kir	Puerto Ric	can, etc.)	White	white
2 T T	Elementary/Secondary (0-12)			during mos	st of working life.	DO NOT us	se retired))	Carpe	entr _v
	17. Father's Name (First, Middle, Kermit End	*		Ourpe			,		ler) Eng	
MD 21 12 should 1 th and Mer 127 is mar umatic ev	19a. Informant's Name/Relations Shirley Engla		Mother	19b. Mailing . 81 4	Address (Street Stewart					n, State, Zip Code) 21
or Heal	20a. Method of Disposition 1 Burial 2 Cremation Donation 5 Other Sp.		n State crem	natory or other	ion (Name of center place) morial Gare			12/8/2010	20c. Location -	City or Town, State
Baltimo	21. Signature of Funeral Service	Licensee		22. Na		elli Fune		me, PA	land, MD 2	
Physician /Medical	23a. Part J. Enter the disease, or failure. List only one cause		used the death. Do		mode of dying, s	such as card	diac or re	spiratory arres	t, shock, or hea	Approximate Interval Between Onset and Death
ixaminer	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a c		101101	Intoxi	Cation				
ted Insit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a c								
xecuted n and l-transit cal Ex	events resulting in death) Last K UNPENDED	d	. ,	_						
	IF FEMALE: 23b. Was decedent pregnant in the	1 Live birt	utcome of pregnand th nt at time of death	₂ Feta	I death 3				23d. Date of Month	delivery Day Year
that the death certification by the attending detached for use as by Physician	1 Yes 2 No 9 Uni	9 Unknow			er (Specify) derlying cause gi	ven in Part	I.	23e. Did tob	acco use contri	bute to the cause of death?
Is, P.O. quires that then signed by and be detacked the tetacked by the tetacked by Feat by Fe	Cocaine use	:					_	1 Yes		Probably 4 Unknown Vere autopsy findings available
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be striffication: To Be Completed								autopsy perform 1 ✔ Yes 2	p <u>ed</u> ? d	nor to completion of cause of eath? Yes 2 No
Vital I ysician: ysician: his certifi director,	25. Was case referred to medica examiner?	Uponital:	patient 2 ER	/Outpatient		of Death (C			esidence 6	Other Scene
ding Physi After this funeral dir	1 Yes 2 No 27. Manner of Death	28a. Date of (Month, D	f Injury 28	b. Time of Inj	ury 28c. Injun	y at Work?	28	d. Describe ho	w injury occurre	
ision Attendi or death. rector: by the f		stigation 28e Place	/4/10 Fo		4 an 1 Y			nk	not and Number	or er Pural Pouta Number City
Division o Hospital or Attending 24 hours after death. Funeral Director: After teld filled in by the funeral Control of the funeral Control on the funeral Control on the funeral Control on the funeral Control on the funeral Control on the funeral cont		d not be I	Found: p			-	A	p C Town, Sta	mber1ai	TP CTINSTE Number, City ad, MD
To the Hospital within 24 hours To the Funeral completely filled	one) 2 Medical Exa	hysician: To the best of miner: On the basis of and manner state	examination and/o		n, in my opinion,	death occu		e time, date ar	nd place, and de	ue to the cause(s)
	29b. Signature and title of certified	elle			29c. License O.C.N				29d. Date signe December	6d (Month, Day, Year) 5, 2010
		who completed cause ssistant Medical			Street, Baltim	nore, MD	21 2 01			
State Registrar	111-11-11-1		istrar's Signature	par	KeS					

DHMH 17 Rev 1/2001 OCME 2006

0

COME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 November 7:04 JOSEPHINE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Days (Month, Day, Year) Months Hours Min. Virginia Director 230-24-8646 88 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Rockville Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13108 20853 USA Grenoble Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 2 1 Never Married 2 Married White If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Baker Dortha Mullins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jan Roberts/Daughter 10730 Daysville Road, Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 and Department of Hamportant: If ite 5 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Parklawn Cemetery 12/2/2010 Rockville, MD injury (4 Donation 5 Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home, PA 21. Signature of Funeral Service Licenses ourine 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Cardiopulmonary disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month Month Year 4 ☐ Pregnant at time of death g ☐ Unknown as been signed by the 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4) Prillation 1 Yes 2 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an bade 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier 星 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Box 68760 Records, Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate heted filled in by the funeral director, page Division of Vital 24 hours сотрете To the I within 2 To the I

Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Hemen

Shal

DEC

MD

c Thamas

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D60417

Frederick

29d. Date signed (Month, Day, Year) 11-29-10

29c. License number

Tohnson DV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registra Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 24, 2010 11;30A. M Anna J. Freda 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Bowie Larkin Chase If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth Oct. 10, 1914 5. Social Security Number 7. Age (In yrs. last birthday 6. Sex Months 1 □ M 2 😾 F Pennsylvania 96 060-16-1789 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County Yes 2□No Maryland Prince George's Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20716 United States 3800 Enfield Chase Court, #325 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2X No Specify Specify: White 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Photography Technician N.I.H 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emily Burian Michael Trancik 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3034 Nutwood Lane Bowie, Maryland 20716 Nicholas M. Freda -son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 12/1/2010 SilverSpring, Maryland 4 Donation 5 Q (Ther (Specify) 21. Signature of Fune I Swice Licens Bonald V: Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final /tm educic disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🏹 No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy death? 1 ∐ Yes 2√⊡No 1 □Yes 2 ☑No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ XVo 1 Inpatient 2 ER/Outpatient 3 DOA

Physician/Medical Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, been signed by the should be detached Completed by his certificate has I director, page 2 s Be Medical Certification: To funeral After within 24 hours after death.

To the Funeral Director: A

Completely filled in by the fu

Physician

/Medical

Examiner

Funeral

Director

r items 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or in y or other traumatic event, Itw Modical Examinations was been

Department of Important: If it any injury or conce.

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

Director

Funeral

\$

Completed

Be

ပ

the Maryland

27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Aditya Chobra, M.D. 600 Ridgely Avenue, #231 Annapolis, Maryland 21401

31. Date filed (Month, Day, Year)

29b. Signature and title of certi-



29c. License number

29d. Date signed (Month, Day, Year)

November 29, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				State of Ma	aryland / Dep	artment of I	Health and N	Mental Hy	/giene	.09.5.0.	
		1	For State Registrar		Ce	rtificate of	Death		Reg. No.2	010	39428
	Physicia	n/	Decedent's Name (First, Middle, Last) Poh	ort A Fo	rranto, Ji	2		2. Date of Do Month Decemb		2ďľo	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give str		ITAIILO, JI	T	or Location of Death			ounty of Death	1910 1
	Lxamiii	CI	11 Blair Lane			E1kto				Cecil	
	Funeral	1	5. Social Security Number 6. Sex	MODE	(In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Bi	irth	9. Birthp	lace (State or Foreigr
	Director		186-38-3112 1 LA	4	7 Yrs.	I working a style		March	6, ^{ve} 1963	De	laware
	how at	'n	10a. State 10b. County	_	10c. City, Town or Lo	ocation			_	10	Od. Inside City Limits
	faryla Ba-f s tified	ect	Maryland Cecil		E1kton						1 ☐ Yes 2 🔀 No
	the N		10e. Street and Number			10f. Zip Code			10g. Citizer	n of What Coun	try?
:	s 23a	Funeral Director	11 Blair Lane			2192				nited St	tates
	death item	Fur	THE THE THE THE THE THE THE THE THE THE	2. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14.	. Race - America Black, White, e	
ရှိ ရ	after I", or xami	d by	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 If Yes, Give	No	1 ☐ Yes 2 🔀 No	Specify:		Spe	ecify: Whi	
ş	nours natura ical E	ete	15. Decedent's Educ	Year or Dates.	16a, Dece	dent's Usual Occup	pation		16b Kind	of Business Ind	
0500-617	filed within 72 hours after death with the Maryland all Hygiener than "natural", or items 23a or 28a-f sho yeent, the Medical Examiner must be notified at	Completed	(Specify only highest grade Elementary/Seconday (0-12)	completed) College (1-4 or 5	1160 1	kind of work done OO NOT use retired,	during most of work)	ing			,
V	withing withing a special withing the special with the special with the special within th	e Cc]	<u> </u>		vner			I	Mushroom	m
yland		To B	17. Father's Name (First, Middle, Last)	0			18. Mother's Nam			name)	
3	should be fil and Mental is marked raumatic ev		Robert A. Ferranto				Roseman				
Mar	2 # 2 #	- 1	19a. Informant's Name/Relationship (Type Eileen V. Palmer/V		- 1	-	${ m e}$ and Number or Run ${ m e}$, ${ m E1kton}$		er, City or Tov 21921	wn, State, Zip C	ode)
ญี่	1 and of Heal item ?		20a. Method of Disposition	-	20b. Place of Disp	osition (Name of				tion - City or To	wn, State
baltimore,	permit, Page 1 a Department of I Important: If its any injury or of		1 ☐ Burial 2 🔀 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		matory or other pla	Inc. 13,	mber 2010	We	st Ches	ster, PA
= = = = = = = = = = = = = = = = = = =	mit. F partm porta y inju	3	21. Signature of Funeral Service Licensee	1	2	2. Name and Addre	ess of Facility Hi	cks Hon	ne for	Funera	ls, P.A.
0	9 5 5 6	i)	Donald S.	Dicks		103 W.	Stockton	Street	Elkt	ton, MD	21921
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused cause ach line	the death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
P	h sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	1 a	n cre	the	Cane	ف		- 1	Onset and Death
and the	Examiner		Toodking in dodiny	Due to (or as a	consequence of):						
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):						
3	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
	execu an an rial-tra		resulting in death) Last	Due to (or as a	consequence of):						
2	hysici he bu	dical	d								
0/00	ding p	Physician/Med	IF FEMALE:	c. If yes, outcome of	of pregnancy						
POX	atn ce attenc for us	cian	in the past 12 months?		2 Fetal death 3	Ectopic pregnan Other (specify)	ісу		230	 Date of delive Month 	ry Day Year
Ď	y the g	hysi	1 Yes 2 No 9 Unknown	9 Unknown							
5	rnar t ned by e deta	by P	Part II. Other significant conditions conf	ributing to death be	ut not resulting in the	underlying cause g	iven in Part I.	23e. Did	tobacco use	contribute to the	e cause of death?
JS,	pures en sigu uld be	edt						1 🗆	Yes 2 🗆 I	No 3 🗆 Prob	ably 4 Unknown
Records,	as bee	Completed						24a. Was	s an 2		sy findings available
ř	ine ia ate ha page	Con						_ perf	formed? 2 No	death?	2 100
	cran; sertific ector,	Be	25. Was case referred to medical examiner?	spital:		26. P	Place of Death (Chec				
5 G	this or	<u>1</u>	1 Yes 2 No.	1 Inpatie	ent 2 ER/Outpatie	nt 3 🗆 DOA	4 □ Nursing Ho	ome 5 Res 28d. Describe			
ם :	th. : After : fune	Certificate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day	Year) injury	wor		Zou. Describe	now injury oc	Scarred	
VISION	Affer er dea ector by the	rtifi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ry - At home, farm, st	reet, factory, office				umber or Rural	Route Number,
≥ :	ralor Insafte al Din ed in			building, etc					wn, State)		
	4 hou -uner: ed fill:	Medical	29a. Certifier 1 Sertifying Physic (Check 2 Medical Examine		my knowledge, death						
-	To the hospital of Attending Prlysician; The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. Within 24 hours after death. Completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Me			est of my knowledge,	death occurred at the	he time, date and place		he cause(s) ar	nd manner as sta	ited.
1	5 ≥ 6 8		235. Signature and the or certifier		m			1118	Zed. Date s	igned (Month) E	ray, rear)

State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department	nt of Health and N te of Death		2010	301.20					
			Registrar 1. Decedent's Name (First, Middle, Last)	Reg 2. Date of Death								
Physician			Charles E. Gladding	November								
	Medic Examin			, Town, or Location of Death								
فكم من رينيه				Ellicott City er 1 Year If Under 24 Hrs.	0.004	Howard						
	Funeral Director		217-18-3294 1 M 2 F 90 Yrs. Months		8. Date of Birth Jan 25, 1	920 g. Birth Coun	nplace (State or Foreign ntry) MD					
	nd thow at	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits					
	Maryla 28a-f s atified		MD Howard Ellicott Cit				1 🗌 Yes 2 🔀No					
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 25a or 28a-f show amportant: If item 27 is marked or event, the Medical Examiner must be notified at once.			p Code L043		. Citizen of What Cou USA	intry?					
		1 1 1	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Dece	dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto		14. Race - Ameri Black, White,						
		ted by	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates. 1945 1 □ Yes				nite					
215-		To	Flementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT us	ork done during most of work e retired)	ing	b. Kind of Business Ir						
2			17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	Accounting	<u> </u>					
lan	l be file fental rked c		Erastus Charles Gladding	I	da Abel							
lary	should and N is ma auma			s (Street and Number or Rura								
	and 2 Health em 27 ther tr		Margaret Youngblood Daughter 7644 Locu 20a. Method of Disposition 20b. Place of Disposition (Na	st Grove Rd.		rnie, MD	21060					
mor	age 1 age 1 at: If its		Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	other place)	l l	rriottsvi						
Baltimore,	permit. F Departm Importa any inju		21. Signature of Funeral Service Licensee 22. Name a	nd Address of FacilityHar	ry H. Wit:	zke's Fami	ly F.H.Inc.					
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between									
J	Physician/		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Onset and Death Due to (or as a consequence of): b. Due to (or as a consequence of): C. Due to (or as a consequence of):									
	Medical Examiner blysician and street burial-transit											
		al Examine										
09/	ate be	edical	d									
89	certific nding use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic	progranov		23d. Date of deli	very					
. Box 687	requires that the death certific been signed by the attending should be detached for use as		in the past 12 months? 1 Yes 2 No 9 Unknown	Month	Month Day Year							
P.O.	s that til gned by be deta	by	Part II. Other significant conditions contributing to death but not resulting in the disconying season grown in act.									
rds	require	eted	Hyper fen fin 24a. Was an 24b. Were autopsy findings av									
Reco	sician: The law r s certificate has t lirector, page 2 s	Completed			autopsy performe 1 Yes 2	prior to c d? death?	ompletion of cause of 2 \(\simega\) No					
tal	cian: ertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec								
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending is completed filled in by the funeral director, page 2 should be detached for use as	Certificate: To	1 ☐ Yes 2 (A) No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 [X] Residence 6 ☐ Other (Specify)									
ision			2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined determined building, etc. (Specify) M 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									
Ω̈́			2ga. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.									
		Medical	(Check only one) 3 Certifying Nurse Practioner: To the basis of examination and/or investigation, in the basis of examination and/or investigation and investigation a	n my opinion, death occurred a	t the time, date and p	place, and due to the c	ause(s) and manner stated.					
			POP Chant	D3Y91-/	1		010					
	124	30. Name and address of person who completed cause of death (Item 23a) (Type, Prigt) EDMUND P TOINK 405 Kednik M m. Le IV3 Cotmon. Ille MD 21227 31. Date filed (Month, Day, Year) 32. Red Strar's Signature										
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar												

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible

			For State	State o		-	artment	of Hea	alth and N	•		່າວກ	10	991	31
			Registrar 1. Decedent's Name (First, Middle,	Last)		Cer	tificate	of Dea	ath	2. Date of De	Reg. No	o	1 0	3. Time of De	ath
	Physicia Medic		ROBERT	J. F	ERK	ETIC				Month			Year 0	0230	М
	Examir		4a. Facility Name (If not institution, g Anne Arundel Me				4b. City, Town, or Location of Death Annapolis					4c. County of Death Anne Arundel			
	Funeral Director		5. Social Security Number 187 – 20 – 9260	6. Sex M 2 D F	7. Age (In yrs. 81	last birthday) Yrs.	If Under 1 Months		Under 24 Hrs. lours Min.	8. Date of Bi (Month, D Jan. 3	rth av, Year) 1, 1	929	9. Birthpl Counti Penns	ace (State or Fo ylvania	reigr
, Maryland 21215-0036	with the Maryland s 23a or 28a-f show ust be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Princ	e George		ty, Town or Lo	cation						10	0d. Inside City L	
			10e. Street and Number 14007 Pleasant View Drive				10f. Zip Code 20720				10g. Citizen of What Country? USA				
	s after death al", or item Examiner n		11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? If Yes, specify Cuban, Mexican, Puerto I				ecify Yes or No- Rican, etc.) 14. Race - American Inc Black, White, etc. Specify: White				tc.			
	nin 72 hours ne. than "natur e Medical E		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business life, DO NOT use retired)						siness Ind	ustry					
	be filed wit ental Hygie rked other ic event, th		2+ Credit Manager Beatrice Foods 17. Father's Name (First, Middle, Last) Michael N. Ferketic Mary D. Vitunic												
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mertal Hygiene. Inmoortant: If time ZT is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship	p (Type, Print)	ter	1			Number or Rura						
Baltimore,			20a. Method of Disposition 1 🏹 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Sp	3 ☐ Removal from pecify)	State	Place of Dispo cemetery, cren Mary erans	natory or othe land ceme te	er place) rv	11/2	Date 9/2010	Cro	wnsv		MD	
Ba	permit Depar Impor any in		21. Signature of Funeral Service Lic	Censee			. Name and A		olis Ro	bert E. ad Bowi				I Home	
jan ja	h sician/ Medical	21 1	23a. Part 1. Enter the disease, or c shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	aa	ch line.	what	er the mode o	of dying, su	uch as cardiac	or respiratory a	rrest,			Approximate Interval Betwee Onset and Dea	n th
	Examiner	ner	Sequentially list conditions, if any, leading to immediate	b. ———	or as a consector as										
	e be executed ysician and e burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to	Due to (or as a consequence of):						+				
200	cate be physicials the bu			d											_
s, P.O. Box 6876	• Hospital or Attending Physician: The law requires that the death certificate 24 hours after death. • Funear Director: After this certificate has been signed by the attending physeted filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Birth 2 Fe nant at time of	tal death 3 🛚	Ectopic pre Other (spec					23d. Dat Mo	e of delive	ry Day Yeal	į.
		ğ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1												
Division of Vital Records,		Be Completed	-							24a. Was auto per 1 \sum Yes	opsy formed?	, r		sy findings avainpletion of caus	
ta			25. Was case referred to medical examiner?	Hospital:				_	of Death (Chec	k only one)					
Ţ		은	1 Yes 2 No 27. Manner of Death	28a. Date	of injury	ER/Outpatier 28b. Time of		Other:	4 🗌 Nursing Ho						
ion o		Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investiga 3 ☐ Suicide 6 ☐ Could n	ation (Mon	(Month, Day, Year) injury work? M 1 □ Yes 2 □ No			28d. Describe how injury occurred							
Divis	ital or At irs after of al Direct ed in by		4 Homicide determin	ned 286, Place buildi	e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	Hospital 24 hours Funeral I	ledical	(Check 2 Medical Ex	Physician: To the b caminer: On the bas Nurse Practioner:	is of examinati	on and/or inves	tigation, in my	opinion, c	death occurred a	t the time, date	and place	e, and due	to the cau	se(s) and manne	r stat

DHMH 17 Rev 7/2009

Registrar

21438

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 39431 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 32 P^M John C. Green November 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death . County of Death Anne Arundel Arnold 464 West Joyce Lane 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) District of Columbia 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Months Days (Month Day 220-42-2060 100 **Director** March 02.1910 Jsual Residence of Decedent at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f sl Arnold Anne Arundel MD 1 ☐ Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21012 USA 464 West Joyce Lane should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black White, etc. þ 1 Never Married 2 Married White If Yes Give 1 ☐ Yes 2 X No Specify: Specify Completed 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working United States life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Patent Agency Director Be permit. Page 1 and 2 should be filled Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Belinda Cawley Kirt Green 19a. Informant's Name/Relationship (*Typ*e, *Print*) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Devon Hill Road Unit A2 Baltimore, MD 21210 Dorothy Ross 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory INC. 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
405 Pitchie Hwv. Severna Park, MD 21146 23a. Part 1. Pater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗌 No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 2 - No 2 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Led , LUIC

State Registrar

31. Date filed (Month,

2 3 2010

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

129 Lubrano Drive Annapolis, MD 21401

H0018097

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11/28/2010 Joseph Ronald Golden 3:00 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Coastal Hospice at the Lake Salisbury Wicomico Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign DE Country) **Funeral** Months Days Hours 9/237 1950 1 **X** M 2 □ F Min. 60 **Director** 220-52-0475 Usual Residence of Decedent or 28a-f show 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester Ocean City 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10343 Keyser Point Rd. 21842 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1

✓ Yes 2

No Black, White, etc. 1 Never Married 2X Married þ should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", 1 ☐ Yes 2x No Specify: white Specify: 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Commercial Fisherman Business owner permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Golden Helen Cleaves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda M. Golden (wife) 10343 Keyser Point Rd. Ocean City, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 x Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sunset Memorial Park 12/2/2010 Berlin, MD 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 21. Signature of Funeral Service Licensee 23a. Pad 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hronic rancheatitis Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner)ia betes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 performed) 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify + Sp) CC ပ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) сотрleted filled in by the funeral Certificate: 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending s after death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Extifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cediff 29d. Date signed (Month, Day, Year) D0058701 30. Name and address of person who completed track of death (Item 23a) (Type, Print) ioth street Oceancy me m) 31. Date filed (Month State

DHMH 17 Rev 7/2009

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Month Patricia Josephine Grunfelder Nov. 28. 4:15 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Brookeville Marian Assisted Living If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Pay, Apr II Birthplace (State or Foreign Country) **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) 1 9 1 Days Hours 1 🗆 M 2 🕱 F 96Yrs Apr Director 577-05-1579 Usual Residence of Decedent show ural", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🍱 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 IISA 1706 Gridley Lane 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 DkNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify.White 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 l of Health and Mental Hygiene. item 27 is marked other than "n other traumatic event, the Medi Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James Francis Dalton Mary Fitzgibbon 19a. Informant's Name/Relationship (Type, Print) - Nephew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9714 Nassau Lane, James Dalton O'Connell Silver Spring, MD 20901 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important; If its any injury or of once, ₽ cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Dec St. John's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Silver Spring, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 yrs Immediate Cause (Final Pnysician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 the as IE EEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Vear Pregnant at time of death Yes 2 X No ed by the a detached f g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. as been signed I 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Atherosclerotic Cardiovascular Disease, 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Recurrent UTI, High Cholesterol, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an History of Myocardial Infarction, has autopsy page death? Parkinsonism certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be 4 Nursing Home 5 Residence 6 Other (Specify) Living Hospital Other: 1 ☐ Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury after death.

Director; Aff 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completed filled in by the 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🔁 🖸 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the l within 2 To the l only one) 29d. Date signed (Month, Day, Year) 28, D12121 2010 Nov. of person who completed gause of death (Item 23a) (Type, Print) 30. Name and address George

Registrar DHMH 17 Rev 7/2009

State

F.

Sengstack,

MD Registrar's Signature

3929 Ferrara Drive, Silver Spring,

MD 20906

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Regina GROSSMANN Month November 2010 9:42 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Future Care at Pineview Prince Georges Clinton 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Sept. 5 ^{Year} 1924 Newryork Director 86 092-18-5020 Usual Residence of Decedent or 28a-f show notified at and 2 should be filed within 72 hours after death with the Maryland Flealth and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges Maryland Clinton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States 20735 Funeral 9106 Pineview Lane 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates 3 ¥ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) <u>Secretary</u> U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Molly Zwieck Jacob Zarofsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2008 Amberleaf Place Waldorf, MD 20602 Robert Grossmann, Son fitem 2 Baltimore, 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 11/29/10 cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) David Memorial Gärden <u>Falls Church.</u> Torchinsky Hebrew Funeral Home Carroll St. NW. Washington. 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ emen disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) e attending physician and The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day sate has been signed by the page 2 should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Decabitus Ulcer 1 Yes 2 No 3 Probably 4 Unknown lodysplasti 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy anetes Mellitus this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 🗔 To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Dea h (Check only one) examiner? 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 [] 3 [] Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. e and title 29b. Sigr atu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ne Ste 203 2835 SM Hh DO 15H 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 30 2014 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 39435 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 16, 2010 8:40 Ella Josephine Goodall November \mathbf{P} M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2736 Lorring Drive # 102 Forestville Prince George 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8 Date of Birth 9. Birthplace (State or Foreign Year) 1<u>923</u> Month, Day 1 🗆 M 2 🔀 F Months Days Hours Min **Director** 87 Wirgi<u>nia</u> 578-40-2574 Jan. Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. sant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Forestville Maryland Prince George 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20747 United States 2736 Lorring Drive # 102 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 A No Specify: Black 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clarence Goodall Emma Carpenter 19a. Informant's Name/Relationship *(Type, Print)* Michelle M. Goodall – Granddaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle M. permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Livia Court Apt. # 10 Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State December 1, 4 Donation 5 Other (Specify) Lee's Crematory Clinton, Maryland 22. Name and Address of Facility Stewart Funeral Home, Inc. Signature of Funeral Service Licen 1001 Benning Road NE Washington, DC 23a. Part Part Venter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Respiratory Failure Medical Due to (or as a consequence of) Examiner Lung Neoplasm l year Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran: that initiated events resulting in death) Last Due to (or as a consequence of): Medical Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☑ 9 ☐ Unknown

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ellen R. Farrell CRNP State

Part II. Other significant conditions cont	tributing to death but not resulting in the under	lying cause given in Part I.	23e. Dic	tobacco use contribute to the cause of death?
	ve Pulmonary Disease		1 [Yes 2 No 3 Probably 4 🗓 Unknown
Hypertension			_ per	as an topsy findings available prior to completion of cause of formed? s 2 ⊠ No 1 □ Ves 2 □ No
25. Was case referred to medical examiner?		26. Place of Death (Check	only one)	
1 ☐ Yes 2 🖾No	ospital: 1 Inpatient 2 ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing Hor	ne 5 🔀 Re	sidence 6 Other (Specify)
27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of injury (Month, Day, Year) 28b. Time of injury	work?	8d. Describe	e how injury occurred
4 Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office		(Street and Number or Rural Route Number, own, State)
(Check 2 Medical Examine	ian: To the best of my knowledge, death occur r: On the basis of examination and/or investigation Practioner: To the best of my knowledge, death	on, in my opinion, death occurred at	he time, date	and place, and due to the cause(s) and manner stated
29b. Signature and title of certifier		29c. License number		29d. Date signed (Month, Day, Year)

R086637

November 26, 2010

21797

Woodbine, Maryland

31. Date filed (Month, Day, Year) DEC O

3250 Starting Gate Court 32. Registrar's Signature

Registrar

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: within 24 hours a

To the Funeral I

2 Medical Examinery on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 1100 33280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21502 MD - 625 Kent Ave., Cumberland, Sunil K. Gupta, 31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 1 4 2010 **ORIGINAL**

State

Registrar

			Please	e Type or Pri					-		egible	
		For State		State of M	larylan		artment of I		Mental Hy	giene ?	010	39437
	_	Registrar 1. Decedent's Name	/Eirot Middlo I s	act)		Ce	rtificate of I	Death	0 Date - (D	Reg. No.	- 1 0	
Physicia		Elfr			ch				2. Date of De Month November		2010	3. Time of Death 10:38 A M
Medic Examin				re street and number)	CII		4b. City, Town, o	r Location of Dea			inty of Deal	
				tion Road				thian	V		ne Ar	rundel
Funeral Director		5. Social Security Nu 355-30-28		Sex 7. Ag 1 ☐ M 2 🔀 F		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	ay, Year)	Co	thplace (State or Foreign untry)
		Usual Residence of	Decedent		84				Mar 9	1926	_	ermany
ied at	Director	10a. State	10b. County		10c. City	y, Town or Lo						10d. Inside City Limits
or 28g	Dire	Maryland 10e. Street and Nurr	Anne A	rundel			Lothian 10f. Zip Code	-		10g. Citizen	of What Co	1 Yes 2 No
s 23a ust be	Funeral	6018 Fi	shers Sta	ation Road			207	11			ed St	-
ritem:		11. Marital Status		12. Was Decedent 1 Armed Forces?	Ever in U.S	3. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. [Race - Ame Black, White	rican Indian,
al", or	od b	1 ☐ Never Marri 3 ☐ Widowed	ed 2 Married 4 Divorced	1 Yes 2 X If Yes, Give Year or Dates.	No		1 ☐ Yes 2 🙀 No			Spec	cifv:	
natur	Completed	(Spec	15. Decedent's l cify only highest g	Education		16a. Dece	dent's Usual Occup	pation	udeim o	16b. Kind o		nite Industry
than than	E O	Elementary/Seco		College (1-4 or !	5+)	Ìife. D	O NOT use retired)		i Kii ig		77	
Hygie other ent, tl	Be	17. Father's Name (F	irst, Middle, Last)	(unk)			omemaker	18. Mother's Na	me (First, Middle,		m Hon	
Menta arked aric ev	욘			(uik)							· ((unk)
7 is m		19a. Informant's Na					ng Address (Street					
Health tem 2 ther t		ROSalle I		nee/daught	_		Old Heral	d Harbor	Road C			MD 21032 Town, State
nt; If if		1 🗌 Burial 2		Removal from State	, C	emetery, crei	natory or other place	· •			-	
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ł	21. Signature of Fun			1 1110		Name and Addre					
22 = 8 9	-	Juan		homes	M009	957 IB	everly L.	Heckrot	te, P.A.	_Clark	svil	e, MD 21029
		23a. Part 1 Enter the shock, or heart Immediate Cause (F	t failure.List only	nplications that caused one cause on each line	d the death e.	n. Do not ent	er the mode of dyin	ıg, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
nysician/ Medical		disease or condition resulting in death)		a. Renal Due to (or as								20 days
xaminer		Sequentially list con	ditions	Diabe								
#5	Examiner	if any, leading to im- cause. Enter Under	mediate lying	Due to for as	а сонзеци	ence oij.						
and la-trans	Exal	Cause (Disease or ii that initiated events resulting in death) L		c. Due to (or as	a consequ	ence of):						
uris dia	<u>a</u>		U	■ d								
ing phy	Physician/Medic	IF FEMALE:										
attendi for use	cian/	23b. Was decedent p in the past 12 m	nonths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Feta	Ideath 3	Ectopic pregnand Other (specify)	су			Date of del Month	ivery Day Year
y the ciched	hysi	1 Yes 2 2 9 Unknown	X No	9 Unknown	it tille of d	eath 5 L						
gned b	by P	_		contributing to death b	ut not resu	ulting in the u	inderlying cause give	ven in Part I.	23e. Did to	obacco use co	ontribute to	the cause of death?
en sig		Alzheime	er's Dise	ease			"		1 🗆	Yes 25 No	3 □ Pr	robably 4 🗌 Unknown
has b	Completed								24a. Was autor			topsy findings available completion of cause of
ificate or, pag		25. Was case referre	d to medical				26 DI	ace of Death (Che	1 🗆 Yes			2 🗆 No
is cert direct	To Be	examiner?	K No	Hospital:	ent 2 🗆 I	ER/Outpatier	nt 3 DOA Othe	er.	Home 5 🔀 Resid	dence 6 \square C	ther (Speci	ifv)
offer th		27. Manner of Death 1 🔀 Natural	5 Pending	28a. Date of inju (Month, Day	ry y, Year)	28b. Time of injury	work	y at :?	28d. Describe h			
death	Certificate:	2 Accident 3 Suicide	Investigatio 6 Could not b	De 28a Place of Init	ırv - At hor	me farm str		Yes 2 □ No	20f Lanation (6	Stand and Min	who wo a v Divi	al Route Number
s after		4 Homicide	determined	building, etc			501, 1401019, 011100		City or Tow		riber or Hur	ar Houte Number,
unera unera ed fille	Medical	29a. Certifier 1	Certifying Phy	vsician: To the best of niner: On the basis of e	my knowle	edge, death of	occured at the time	, date and place, a	and due to the ca	use(s) and ma	nner as sta	ted. ause(s) and manner stated.
ithin 2 o the F omplet	— r	only one) 3 29b. Signature and ti	Certifying Nur	se Practioner: To the	best of my	knowledge, o	death occurred at the	e time, date and pl	ace, and due to the	e cause(s) and 29d. Date sign	manner as	stated.
≥ ₽ 8)	2/ or	75			D38			_		30, 2010
	ŀ	30. Name and addres	ss of person who	completed cause of d	eath (Item	23a) (Type, F				1,000		20, 2010
		Wayne Bi	ierbaum 1	34 Owensv	ille :	Road	West Rive	er, Mary	land 207	78		
State Registra	e r	31. Date filed (Month	DEC 0 1 2	010 32. Pegistra	ar's Signati اسالات	9. A	arked					
				17.7		- Page					_	

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene 1 - State Amended #7 per fh, RG FCHD 12/7/10/cate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Markh																	
													I		102 () 1		3. Time of Death	
	Physicia Medic		William C. Hu	itchi	nson								Month Novembe		ey Yea		5:40 A.M	
	Examin		4a. Facility Name (if not institu			nber)		4b	o. City, Town	, or L	ocation o	of Death			c. County of D			
ч			Northhampton	Mano	r Healt	ch (Center	_]	Freder	ic	k			F	rederi	ck		
	Funeral		5. Social Security Number	6. 8		7. Age	e (In yrs. last birthd	M	f Under 1 Ye onths Dav		If Under :	24 Hrş. Min.	8. Date of Bir		9.	Birthpl Countr	ace (State or Foreign	
	Director		577-48-6071 Usual Residence of Deceden		LES IVI Z L	74	-67 Yr	S.					Feb. 2	I, 1	1936		D.C.	
	nd how at	ř	10a. State 10b. Co				10c. City, Town o	r Locatio	on							10	d. Inside City Limits	
	aryla ta-fs ified	Director	MD E-	- d - m	i ole		Frederi	- 1c									1 ¥ Yes 2 □ No	
	or 28	ä	MD Fr 10e. Street and Number	eder:	LCK		rrederre		10f. Zip Cod	е			T	10a, C	itizen of What	Count	rv?	
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at , the Medical Examiner must be notified at	Funeral	200 E. 16th	Stre	et				2170	1			ŀ	USA	A			
	tems r mi	Ę.	11. Marital Status		12, Was Dece	edent E	ver in U.S.	13. Was	Decedent o	f Hisp	anic Orig	gin? (Spe	cify Yes or No-		14. Race - A	merica	n Indian,	
9	or i	ρ	1 Never Married 2	Married	Armed Fo	2 🗌	No		s, specify Cu Yes 2 🔼			, Puerto	Rican, etc.)		Black, W			
8	urs al ural"	Completed	3 Widowed 4 A Divo	ced	Year or Da	etes19	57-60	- ' -	res 2 🗆	NO	Specify:				Specify: Wh	ite		
5	"nat	ed			ducation ade completed)		1 (0	live kind	's Usual Oco I of work dor	ne dur		of worki	ng	16b.	Kind of Busine			
121	within 7 giene. ner than t, the M	힍	Elementary/Seconday (0-	2)	College (1	-4 or 5	+) lif		OT use retire	-					1			
2	ed wi Hygie other ent, tl	Be (12 17. Father's Name (First, Midd	lle Lasti				U	ashie		9 Matha	r'o Name	e (First, Middle,		retail			
Maryland 21215-0036	2 should be filed th and Mental Hy 27 is marked oth traumatic event	인	William H. H		ingon					'			0. Moo		i Surname)			
Ž	ould nd Me mari		19a. Informant's Name/Relat				19b A	Aailing A	ddroes (Stro	et and			l Route Numbe		or Town State	Zin Co	nde)	
Š	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 2be notified at other traumatic event, the Medical Examiner must be notified at		Nancy Garret	. ,									ederick				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
ē	1 and 1 and of Healt item 2		20a. Method of Disposition		_		20b. Place of D			. ()			Date	20c.	Location - City	or Tov	n, State	
e E	Page nt c nt: If ny or		1 ☐ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth			State			ory or other p		, 11	2/02	/2010	Fr	edericl	r. 1	m .	
20a. Method of Disposition 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22b. Place of Disposition (Name of cemetery, crematory or other place) 22c. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Pike, Frederick																		
m	a II De	: 13) (July C	1	nu	-	1).	1621	l Opos	sur	ntown	n Pi	ke, Fre	der	ick, MI	21	.702	
			23a. Part 1. Enter the diseas shock, or heart failure. I	, or com	plications that one cause on ea	caused	the death. Do not	enter the	e mode of d	ying,	such as o	cardiac o	r respiratory ar	rest,			Approximate Interval Between	
	Inysician/	6 25	Immediate Cause (Final disease or condition	iot omy c				mie	, 1								Onset and Death	
	Medical		resulting in death)		a. Due to	or a	povale, consequence of):		•									
	Examiner	L	Sequentially list conditions,	-	b	SI	BIRRO	ing	_							Hour		
	70 ±	Examiner	if any leading to immediate cause. Enter Underlying	2	Due to	or as a	consequence of	U									1	
	and trans	xan	Cause (Disease or linjury that initiated events resulting in death) Last		c. Due to	or oo o	consequence of):									+-		
_	death certificate be executed ne attending physician and ed for use as the burial-transit		resulting in deathy cast		. Duc to	(O) 43 4	consequence on,											
760	physi the t	edical			d											+		
.89	ertific Iding Ise as	Ž	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, out	come o	of pregnancy								23d, Date of	dolivor	.,	
Box 687	eath certifica attending pl	Physician/Me	in the past 12 months? 1 Yes 2 No	f			2 Fetal death time of death		ctopic pregna ther <i>(specify)</i>					1	Month		y Day Year	
B	he de y the tched	hys	9 Unknown		9 🗌 Unkr	nown												
P.O.	requires that the de been signed by the should be detached	by P	Part II. Other significant con	ditions c	ontributing to d	eath bu	ut not resulting in t	he unde	rlying cause	given	in Part I.		23e. Did to	obacco	use contribute	to the	cause of death?	
S,	uires n sign	ed t											1 🗆	Yes 2	2 ₹ No 3 □	Proba	ably 4 🗆 Unknown	
Ö	w req	Completed											24a. Was				y findings available	
3ec	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No No 1 Yes 2 No No No No No No No																	
a	ian:] rtifica ctor, p		25. Was case referred to med examiner?						26.	Place	e of Deatl	h <i>(Check</i>	only one)	2 00		100 L		
₹	hysic nis ce I direc	은	1 🗆 Yes 2 🕱 No				nt 2 ER/Outp	atient 3	DOA C	ther:	4 🚺 Nui	rsing Ho	me 5 🗆 Resid	dence	6 Other (Sp	ecify)		
of	ing Pl	28d. Describe how injury occurred 28d. Describe how injury occurred injury work?																
ion	tendi Jeath. tor: A the fu	iţic	2 Accident Inv	estigation						_	s 2 🗆	No						
Division of Vital Records,	or At after o Direct in by	Certificate:		ermined	28e. Place		ry - At home, farm (Specify)	, street, 1	factory, offic	e		1	28f. Location (S City or Tow			Rural F	oute Number,	
	pital ours a eral [29a, Certifier 1 Certif	dog Dhy	ninianu To tho h	ant of r	ny knowledge, de	ath occu	red at the tire	no de	ato and a	loos on	d due to the co			_4_4_4		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medic	al Exam	iner: On the bas	of ex		vestigati	ion, in my op	inion,	death occ	curred at	the time, date a	and plac	e, and due to th	ne caus	e(s) and manner stated.	
	o the vithin to the comp	2	29b. Signature and title of cer		Se i Actioner.	NO LITE L												
			•	-	-				D	43	091				11-30.	- 2	010	
	'		30. Name and address of per-				eath (Item 23a) (Typ	e, Print)	1 1		.01	1	7		,	-	(a 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
	TIVA		Saeed		idi Mi		801	700	u H	ĐW.	se 1	TVE	1 /2	ene	rick	14	1)21/01	
		29b. Signature and title of certifier 29c. License number D 43091 29d. Date signed (Month, Day, Year) 11-36-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar 31. Date filed (Month, Day, Year) DEC. 29d. Date signed (Month, Day, Year) 11-36-2010 April 19-36-2010 29d. Date signed (Month, Day, Year) 11-36-2010 10-36-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) House Ave, Rederick, MD 21701 State Registrar 31. Date filed (Month, Day, Year) DEC. 29d. Date signed (Month, Day, Year) 11-36-2010																

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary Rose T. Higgins 7:35 2010 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis Anne Arundel Medical Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 5, 1925 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 🂢 F 195-20-0308 85 Director Pennsylvania Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Bowie Prince George's 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12402 Ryland Court 20715 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 X Widowed 4 Divorced Specify Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Ве 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luke Corrigan Rose McKane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter Ayerle / Son-in-law 601 Robinson Place Court Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Demoval from State Baltimore, MD Metro Crematory, INC. 2010 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fund Service Licenses 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ chronic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if only being course, in the cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death
Unknown signed by the a d be detached f g 🗌 Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Fibrillatio 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) s after death. al Director; After this ં લ્લે in by the funeral dir 1 🗌 Yes 2 No ပ္ 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 🗌 No Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Tpleted f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 **To the F** 3 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and titl of certifier 29c, License number 29d. Date signed (Month, Day, Year) 18

Sta

State Registrar 31. Date filed (Month, Day, Year)

NOV23

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen Olero Adm (

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH C910 12/15/10 III
State of Maryland / Department of Health and Mental Hygiene 2 [] [State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12:10 A M BERNARD CLIFTON November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick <u>Frederick Memorial Hospital</u> Frederick If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 6. Sex 1 Å M 2 ☐ F Days Hours 83 washington. **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 1 No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 915 Snider Lane 20905 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give WW I I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White. Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Metropolitan Police Elementary/Seconday (0-12) College (1-4 or 5+) Officer Department Police Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifton D. Hollis Bertha Cleary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11709 Barn Swallow Place, New Market, Maryland 21774 Susan M. Preston - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cem. 12/03/2010 | Silver Spring, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, MO # 1070 1800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease ar ondition resulting in death) Onset and Death Ph sician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-trasit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed line of in by the Invertal director, page 2 should be detached for use as the burlat-traisit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ☐ Live Birth 2 ☐ Fetal deat ☐ Pregnant at time of death ☐ Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 X No မြ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending Accident Work: 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 26 M Tolino 10 IND 51616 Michael TOLINO, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21702 Snite 201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 39441 State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph Month November 27, Hill 2010 11:44 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Year) 1935 1 🖾 M 2 🗆 F Days Min. Aug. 19 522-46-2356 75 **Director** Yrs Usual Residence of Decedent 28a-f shov 10b, County Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 1412 Winding Waye Lane 20902 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗌 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXo Specify: Specify: White d Mental Hygiene. marked other than "natural"; 3 Divorced 4 Divorced Completed Year or Dates. 1958-86 permit. Page 1 and 2 should be filed within 72 hour popartment of health and Mental Hyglene. Important: If item 27 is marked other than "natuu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Operating Room Nurse Army Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Oliver Perry Hill Helen Imboden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Irene Hill/Wife 1412 Winding Waye Lane, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Nov. 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, VA 2010 21. Signature of Funeral Service Licenses Francis Address Collins Funeral Home Inc. 11101503 500 University Blvd. W., Silver Spring, MD 20901 23a. P rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death 10 mins Physician/ Acute Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence or) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Medical Box 68760 attending pl IF FFMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Year Day signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, Diabetes Mellitus-Type II, Records, 1 \square Yes 2 \boxtimes No 3 \square Probably 4 \square Unknown Hyperlipidemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed' 2 🗌 No 1 🗌 Yes Yes 2 🗷 No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tyes 2 🙀 No ည 1 ☐ Inpatient 2 ₺ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 🗌 Yes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2 29b. Signeture and title of certifi 29d. Date signed (Month, Day, Year) 20 D12121 Nov. 28, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George T. Sengstack, MD 3929 Ferrara Drive, Wheaton, MD 20902 31. Date filed (Month, Day, Year) Registrar's Signat State

DHMH 17 Rev 7/2009

Registrar

MOA 3 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 23a, b per me g912 2-7-11 vt
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year Esperanza Hernandez Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death P.G. Hospital Center Cheverly P.G. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours Min. June 3, 1 🗆 M 2 🖾 F 191<u>4</u> 215-58-8044 96 Director Yrs Cuba Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 28a-f 1 Yes 2 No P.G. College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 5002 Paducah Road 20740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ould be filed within 72 hours after d nd Mental Hygiene. marked other than "natural", or i Black White etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 X Yes 2 □ No Specify: Cuban Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be Department of Health and Mental Hy, Important: If item 27 is marked any injury or other any or other any or other any or other any or other any or 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jose Rodriguez Catalina Mesa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ledis M. Hernandez/Daughter 5002 Paducah Road, College Park, MD 20740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation STA Other (Specify) entombrent $^{N}2$ 810 30 Gate of Heaven Cemetery Silver Spring, MD Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Multiple Injuries with Complications 23a. Part 1. Enter the disease, or cor shock, or heart failure. List only ne ause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury that the death certificate be executed that initiated events resulting in death) Last ending physician an use as the burial-tr Due to (or as a consequence of) Physician/Medical Box 68760 use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Ö Month Day Pregnant at time of death the P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 No death? 1 Yes 2 No Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Division of Vital æ 26. Place of Death (Check only one) examine Yes 2 🗆 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 4 hours after death. uneral Director: After this ed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of down Certificate: 28c. Injury at 28d. Describe how injury occurred Fell 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending injury work? at STURINS 0260 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State fre.
in 24 hours.
o the Funeral Di
completed filler home college Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 20053703 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tsion Berhane, MD 4404 Queensbury Road, Riverdale, MD 20730 31. Date filed (Month, Day, Year) 82. Registrar's Signature State **NOV 3** 0 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ V. Hammond 22, 2010 Doris November 7:35 ам Medical 4a. Facility Name (if not institution, give street and number)
The Village at Harbor Point 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Wicomico Salisbury Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🔼 F Months Days Hours Min 03/03/1925 85 Maryland **Director** 218-16-6795 ral", or items 23a or 28a-f show Examiner must be notified at 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 611 Tressler Dr., Village at Harbor Pt USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. "natural", white Specify: Completed 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 I and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) health care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Townsend Wilmer Hammond 19a. Informant's Name/Relationship (Type, Print)

June Elliott niece 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip, Code) 3521 St. Lukes Rd., Salisbury, MD 21804 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important; If ite Date 1 X Burial 2 Cremation 3 Removal from State 11/27/2010 4 ☐ Donation 5 ☐ Other (Specify) Parsons Cemetery Salisbury, MD 21. Signature of Funeral Service Licensee ²²Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition ve to Medical resulting in death) Due to (or as a consequence of) Examiner 2 heimers Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and -trans Due to (or as a consequence of): burial Physician/Medical that the death certificate be 68760 phys the L attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown Records, Completed been signatures should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 100 မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending hours after death.

neral Director: Aft
d filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, An.
An 24 hour.
A the Funeral Dr.
completed fille Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Iwithin 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certified erson who completed cause of death (Item 23a) (Type, Print) 0. Name and address of 1205 Senter WI

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

NUV

29

32. Registrar's Signature

amend #55 RecoFMaG9110d 120666/thenttof Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Syril John Henry Physician/ Hackett 2010 5:10 p M November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 36081 Purnell Crossing Wicomico Willards If Under 1 Year If Under 24 Hrs. Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🏻 M 2 🗆 F Months New York 1671271943 214-42-2262 67 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 🗌 Yes 2 🗶 No Willards Maryland Wicomico 10e. Street and Number 10f. Zin Code 10a. Citizen of What Country? Funeral 36081 Purnell Crossing 21874 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces? Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: white Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) line worker Tyson Foods Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles S. Hackett Nahdelle Crawford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43 Sands Court, Conowingo, MD 21918 Robert E. Jones/step-son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 11 29 2010 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Service Licensee CFSP dompoor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, UPPER GASTROINTESTINAL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner SASTROESOPHAGEL Se uentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes No 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To . Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending worl 1 Tes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4

Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. d title of certifier 29b. Siar 58755 e and address of person who completed cause of death (Item 23a) (Type, Print) donMD 31. Date filed (Month, Day, Year) Registrar's Signature NOV 29 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 23, 2010 12:55P M Marie Johnson Kay Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 16429 Keats Terrace Derwood 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 28, 1938 9. Birthplace (State or Foreign **Funeral** Days Min. 1 □ M 2 🗓 F Months Hours Country) Yrs **Director** Texas 460-60-6412 Usual Residence of Decedent f shov 10a. State 10h County 10c. City, Town or Location Ħ 10d. Inside City Limits Director 3a or 28a-f sh 1 🗆 Yes 2 🖵 No Maryland Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral J Hygiene. I other than "natural", or items 23a vent, the Medical Examiner must t 16429 Keats Terrace 20855 United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. If Yes Give Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Homemaker</u> Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked of traumatic ever မ should be Curtis Ford Williams Dora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other tra once. Health Thomas E. Johnson/husband 16429 Keats Terrace Derwood, Maryland 20855 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 11/27/2010 Woodbine, Maryland . Sigrature of Funeral Service Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 ianita Moman M00957 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Lung Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and s the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of) Physician/Medical 68760 igned by the attending p be detached for use as IF FEMALE f yes, outcome of pregnancy

Live Birth 2
Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☒ No Year Month Day Pregnant at time of death g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ law requires Records, 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autop performed: page The certificate **Division of Vital** funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 X No Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ctifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature an title of 29c. License number 29d. Date signed (Month, Day, Year) D35635 November 24, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, M.D. 18111 Prince Philip Drive Olney, Maryland 20832

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

NOV 1 9 2010

Amend #10e per FD Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AACO Health Dept. 11-19-10 KAH

1-State Registrar State of Maryland / Department of Health and Mental Hygiene 2. Date of Death 3. Time of Death 2010 1215 AM 10 4c. County of Death N/A 8. Date of Birth (Month, Day OCt 27 9. Birthplace (State or Foreign ^{Year)} 1931 Maryland 10d. Inside City Limits 1 ☐ Yes 2X No 10g. Citizen of What Country? USA Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry General Motor's 18. Mother's Name (First, Middle, Maiden Surname) Nannie Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Md. 21229 20c. Location - City or Town, State Annapolis, Md. Milleme & Addes of cilions Mortuary, F.A. 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 res 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 1000 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) NOV 10, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Nov Conbe Richard John JONES 0420 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hagerstown Washington Washington County Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral ^{Year)}19<u>32</u> July 21 201-24-9085 **Director** 78 Pennsylvania Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10b. County 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director Maryland Washington Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 21740 17521 Green Meadow Lane USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 5 þ 1 Never Married 2 Married 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1953-1961 1 ☐ Yes 2 X No Specify: white Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) machine operator warehouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Mitchell Jones Irene Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol George 17521 Green Meadow Lane, Hagerstown, Md. 21740 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 Burial 2 X Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) 12/1/10 Hagerstown, Maryland Hagerstown Crematory 21. Signature of Funeral Service Licens 22. Name and Address of Facility MINNICH FUNERAL HOME Š 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final IENTR! Onset and Death Physician/ CULAR TACHY CARDIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine ACUTE Cause (Disease or linjury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of) attending physician Physician/Medical H CART Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? 1 Yes 2 No 9 Unknown Month signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy death? certificate 1 ☐ Yes 2 ☐ No Yes 2 No he Funeral Director: After this certific upleted filled in by the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 1 Yes 2 No ြု 1 🔄 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 24 hours after death. 5 Pending 1 Natural injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

SH 8+1

State Registrar

S. AZIZ MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOHAMMFD

D6689Z

intelan St. Hageistown

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 39448 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Helen Johnston 7:15am Medical 2010 November 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3152 Gracefield Road, MS 224 Prince George's Silver Spring **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days New York Months Hours Min. July 27, 1920 Director 120-03-2950 90 Yrs. Usual Residence of Decedent 28a-f shov 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Prince George's Silver Spring 1 Yes 2 X No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3152 Gracefield Road, MS 224 20904 U.S.A. tems 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Director of Distribution Mamt. Publishina is marked other it. Page 1 and 2 should be filed withment of Health and Mental Hygintrant; If item 27 is marked other rightry or other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Robert Downey Josephine Otter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Dolan - Nephew 11317 Classical Lane. Silver Spring, Maryland 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of h
Important: If ite
any injury or ott 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) incoln Crematory 12/01/2010 | Brentwood, Maryland of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 1 1 / 03 / 2010 Physician/ Neoplasm. Brain. Metastatic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) eath cerun... re attending physician and rese as the burial-transit cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day 2 X No been signed by the should be detached 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ Completed 1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe Director: After this certificate Yes 2 X No 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 Yes 2 🗶 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛛 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funeral Direct completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) Undelle New D36716 November 26, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew George Kundrat, M.D., 3110 Gracefield Road, Silver Spring, Maryland 20904 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1994 9

			For State Registrar	State of Maryla	•	artment of <i>tificate of</i>				g. No.			
	Dhysisia	~ /	Decedent's Name (First, Middle, Last)					2. Da	ite of Death		Voor	3. Time of Deat	:h
	Physicia Medic	al	Amy Virgin					11			Year OID	3:55A	М
	Examin	er	4a. Facility Name (if not institution, give str			4b. City, Town,				4c. County	5		
A.	Funeral		5. Social Security Number 6. Sex	+ The Lake	. last birthday)	If Under 1 Year	bur	e 24 Hrs. 8, Da	te of Birth	Wico		ace (State or For	eian
	Director		242-54-3003 1 ¹	- 377	75 Yrs.	Months Days	s Hours	Min. Jur	ne 30,	^{ear} 1935	NC	(Y)	
	and show	ō	Usual Residence of Decedent 10a. State 10b. County	10c. 0	City, Town or Lo	cation					10	d. Inside City Lin	nits
	Maryl 28a-f otifiec	Director	MD Wicomico)	Salisbu	ıry						1 ☐ Yes 2X	No
	th the	al D	10e. Street and Number			10f. Zip Code			10	g. Citizen of W	hat Count	ry?	
	ath wil	Funeral	1631 Waconia Driv	7C 2. Was Decedent Ever in U	18 12 1	2180		Origin? (Specify Vo	s or No-	USA		- Indian	_
9036	ırs after de ural", or ite I Examiner	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【▼ Divorced	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	1	f Yes, specify Cu		Origin? (Specify Yes can, Puerto Rican, lify:	etc.)	Black	- America i, White, e Blac	tc.	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)		(Give	dent's Usual Occi kind of work done O NOT use retire OOTET	e during m	ost of working		ib. Kind of Bus Peninsula Cen	Regio	ustry Onal Medic	al
b	should be filed with and Mental Hygier h and Mental Hygier 7 is marked other traumatic event, the	Be	17. Father's Name (First, Middle, Last)			,020=	18. Mo	ther's Name (First,	Middle, Mai	iden Surname)			
<u>ya</u>	Menta Menta narked	욘	Carrie Whitaker				Pen	nie Batt	le				
Maryland	2 shouth and the and the strain.		19a. Informant's Name/Relationship (Type	•				ber or Rural Route Washingt				ode)	
	of Heal of Heal fitem		Joyce Elaine Jones, 20a. Method of Disposition	20b	. Place of Dispo	sition (Name of		Date		Oc. Location - 0		vn, State	
<u><u>E</u></u>	Page 1 ment of ant: If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crem pringhill	natory or other pi Memory G	rdens	11/29/20		Hebron			
Baltimore,	permit. Departn Importa any inju		21. Sinnature of Funeral Service Licensee	Joller Joller		Name and Add		Sa 1 Chapel	lisbu - 12	ry, Mar 13 Jers	ylan sey R	d oad 2180)1
1			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	cause on each line.								Approximate Interval Between	
	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	MALIGNA	NT /	3 RBAS	TC	ANCRO				Onset and Death	
No.	Examiner			Due to (or as a conse	quence of):								
	- ±	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence of):								
	ecutec and -trans	xan	Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a conse	auence of):						-		
0	ficate be executed g physician and as the burial-transit	ical	d	,	,								
8760	<u>≠</u> 50 8	Med	IF FEMALE:										_
Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as it	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of preg 1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	Ectopic pregna Other (specify)	ncy			23d. Date Mon	of deliver	y Day Year	
P. O.	v requires that the der been signed by the s should be detached	by Ph	Part II. Other significant conditions contr	ibuting to death but not r	esulting in the u	nderlying cause	given in Pa	ort I. 23	e. Did tobac	cco use contrib	ute to the	cause of death?	
	quires en sign	ted b					_		1 \square Yes	2 (No 3	B 🗌 Proba	ably 4 🗆 Unkno	own
Vital Records,	law rei as be	Completed						24	la. Was an autopsy	pr	ior to com	sy findings availal pletion of cause	ole of
æ	sician: The law is certificate has birector, page 2 s		25. Was case referred to medical						· · · · · · · · · · · · · · · · · · ·		eath?	. □ /17 0	
/ita	rsiciar s certif	To Be	examiner?	spital:	T EB/Outpation	In		eath (Check only or Nursing Home 5		- Post	(0/5-)	Valeic &	
ot	ng Phy ter this neral o		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Inju		•		injury occurred	_	1/03/10/1	
ion	tendile death. tor: At the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be			M 1[Yes 2						
Division of	al or At s after (I Direct d in by		4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		eet, factory, office	•		cation <i>(Str</i> ee y or <i>Town</i> , S	t and Number state)	or Rural F	Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check	an: To the best of my kno On the basis of examinat	ion and/or invest	igation, in my opin	nion, death	occurred at the time	e, date and p	place, and due t	o the caus	e(s) and manner s	tated
	o the vithin 2 the comple	Š	only one) 31 Certifying Nurse F 29b. Signature in title of certifier	ractioner: To the best of	my knowledge, o	leath occurred at 29c. Licen				use(s) and man			
						De	058	410					
6	unh		30. Name and address of person who com	pleted cause of death (Ite	em 23a) (Type, P	rint)		410 ALISB	1011	1 ,110		(307	
6	CIC.		31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature /	1733	5	KUIS	wy	wa	V	1006	
	Stat Registra	e	31. Date filed (Month, Day, Year) 2010) Linux	B. 100	wed			/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

/Medi	an cal	1. Decedent's Name (First, Middle, Last) CAYLE NORTON						DEC . 3		3. Time of Death
Exami		4a. Facility Name (If not institution, give 9840 PENNS HI	LL ROAD			LA PLAT	'A		4c. County of De	ES
Funeral Director		5. Social Security Number 578-40-0659 Usual Residence of Decedent		82 Yrs.	If Under 1 Months	1 Year If Under Days Hours	Min.	8. Date of Birth	9. E WA	Sinthplace (State or Foreig
filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23a or 28a-f show ther the Medical Examene must be notified at	tor	10a. State 10b. County CHARI		City, Town or L		LA PLAT	'A			10d. Inside City Limit
h with the 23a or 28 at the not	Funeral Director	10e. Street and Number 207 HEATHER CO	OURT		10f. Zip (Code 20646		10	0g. Citizen of What o	Country?
if Health and Mental Hygiene. If Health and Mental Hygiene. If Health and Mental Hygiene. If Item 27 is marked other then "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinations to natified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ ② Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	U.S. 13.	Was Decede If Yes, specif 1 Yes 2	ent of Hispanic Or fy Cuban, Mexical No Specify:	n, Puerto F	offy Yes or No- lican, etc.)	14. Race - Ar Black, WI Specify W H	
filed within 72 ha Hygiene. Ither then "naturent, the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1 2	catio <i>n</i> e <i>completed)</i> College (1-4or 5+)	(Give	DO NOT use	k done durina mos	t of workin	g	16b. Kind of Busines	ss/Industry MED. CENT
ond Mental Hy marked oth martic event	To Be (17. Father's Name (First, Middle, Last) GEORGE PETER	KIMMEL						Maiden Sumame) ES NORTO	N
Health and tem 27 is most		19a. Informant's Name/Relationship (Ty KIM WEAVER-DAUC	SHTER	984	O PEN	NS HILI	RD.	LA F	City or Town, State	. 20646
nent cand		20a. Method of Disposition 1 ☐ Burial 2 ☐ Termation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State METRO	Place of Disponentery, cre POLIT.	matory or oth	her place)			20c. Location - City ALEX • , VA	
permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service Licens.	M00479	(3	AYMO LA PL	Address of Facili ND FUNE ATA, MAR	RAL YLAN	SERVIC ID 2064	CE,P.A.	
Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection).	equence of):		Cance	cardiac of	теарпасоту атте		Approximate Interval Between Onset and Death
Ine law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE	Due to (or as a consect. 3c. If yes, outcome of pregramment to 2 Ferman Street 4 Pregnant at time of 9 Unknown	nancy tal death 3[death 5[□Ectopic pre □ Other (spe	ecify)		23e. Did tob	23d. Date of o Month	delivery Day Year
law requires as been sign s 2 should be	Completed by							1 de 24a. Was ar autops	n 24b. Were	Probably 4 _Unknow autopsy findings availate to completion of cause of
	Be Con	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 [ER/Outpatie	f 28	A Other: 4 No	ursing Hom	Check only one	2 No 1□Y	es 2□ No Daughter PecifyResidence
ting Physicien: 1. After this certifica funeral director, p	မှ	27. Manner of Sath 1 Natural 5 Pending Accident investigation	(Month, Day Year)		M	1 ☐ Yes 2 ☐				
ang Priysicien. 1. After this certifice funeral director, p	မှ	1 ☑Natural 5 ☐ Pending	(Month, Day Year) 28e. Place of Injury - At building, etc. (Spec	home, farm, st			2	8f. Location (Sti City or Town		Rural Route Number,
this certificaral director, p	0	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Physical Control of the determined	(Month, Day Year) 28e. Place of Injury - At	home, farm, st	h occurred a	office	nd place, a	City or Town nd due to the ca d at the time, da	o, State)	as stated. due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene Registrar

State of Maryland / Department of Health and Mental Hygiene Registrar

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER MARY FLORENCE KEARFOTT 7:03 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2XXF 96 Days ^{Year)}1914 212-14-7680 Months Hours Maryland Director Usual Residence of Decedent show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Brunswick XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 405 9th Avenue 21716 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurses Aid Medical permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other t any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ross Wenner Helen Humphrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Phillips - nephew 8002 Clearfield Road, Frederick, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Stauffer Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11-30-2010 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) e of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Hoort Pauluve Immediate Cause (Final Congestivo Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 1 Yes 2 g Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N page 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Be 2 **X**No Other: 1 \square Yes ပ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural Accident 5 Pending iniury work? 1 Yes 2 No Division within 24 hours after death.

To the Funeral Director: Af Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only of Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signati 29d, Date signed (Month. Dav. Year) 11/26/10 00062223 of person who completed cause of death (Item 23a) (Type, Print) FREDENICE, MO 21702. PRAYERY BOLHLUY ,196 TJOUVE, 32. Registrar's Signature 31. Date filed (Month, Day, Year, State Eneral Registrar

DHMH 17 Rev 7/2009

ORIGINAL

Natae	Chanece	Kasey

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

· ·	, , , ,	1- For State Registrar Amend#16ap	erfuneralhom&P				, ,	eg. No.	39452
Physic Medical Exam		Decedent's Name (First, Middle,La	ast)	<u> </u>			2. Date of Dea		3. Time of Death
		4a. Facility Name (if not institution, g	ive street and number)		-	or Location of De		4c. County of Dea	
Euporol		Southern Maryland Hosp 5. Social Security Number 6.5	ital Sex 7. Age (In yrs. I	ast hirthday)	Clinton	ear If Under 24	Ure 19 Date of Pir	Prince Georg	je's irthplace (State or Foreign
Funeral Director		577 13 7217	_M 2 XF 24	Yrs.			Min. 6-16-	1986 Wa	ountry) ShingtonDC
any		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Locati	on				10d. Inside City Limits
faryland 28a-f show at once.	ō		George's B	ladens	burg				1 X Yes 2 No
th the Mary 23a or 28a- notified at	Ģ	10e. Street and Number 4261 58th Ave.			10f. Zip Code			0g. Citizen of What Co USA	untry?
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Marrie	d 12. Was Decedent Ever in U. Armed Forces 2. 1 Yes 2 No			Hispanic Origin? an, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	- 14. Race - Ame White, etc.	rican Indian, Black,
after d ral", or	ð F		d If Yes, Give Year		Yes 2X			Specify:Bla	ck
2 hours "natur	ted	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5+)			eation (Give kind fe. DO NOT use		16b. Kind of Business	/Industry
MD 21215-0036 2 should be filed within 72 hours afte, th and Mental Hygiene. 27 is marked other than "matural" umatic event, the Medical Examines	Completed	11th		Telem	arker	Telemar	keter	Private	
215-003 be filed withi ntal Hygiene, rked other th ent, the Med	Be Co	17. Father's Name (First, Middle, Las Alvin Palmer	t)				me (First, Middle, N a Kasey	Maiden Surname)	
2121! hould be fill ad Mental F is marked	To B	19a. Informant's Name/Relationship (** '	19b. Mailing	Address (Str			nber, City or Town, Stat	e, Zip Code)
	A 6	Benita Kasey/ 20a Method of Disposition		4261 Place of Disposi				g,MD 2071	
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and Nimportant: If item 27 is ninjury or other traumatie		1 XXBurial 2 Cremation 3	Removal from State	rematory or oth	er place)	[12	/4/2010	20c. Location - City o	·
Baltimo permit. Page Department or Important: injury or oth	l è	4 Donation 5 Other Specify 21. Signature of Funeral Service Lice					riscoe-	Conic Fun	
	. 1	Simeraly Char	exectour	_ 22	94 old	l Washi	ngton Re	d.Waldorf	
Physician /Medical		23a. Part I. Enter the disease, or comfailure. List only one cause on e	ach line.	Do not enter the	e mode of dying	g, such as cardia	c or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease a or condition resulting in death)	Multiple Injuries Due to (or as a consequence of):					Deau
	er	Sequentially list conditions, bif any, leading to immediate	Due to (or as a consequence of):					
	Examiner	cause. Enter Underlying Cause	Due to (or as a consequence of						
cuted md transit		events resulting in death) Last		,				_	
O, be exe sician a	Medical	UNPENDED	AMENDED						
tox 68760, cath certificate be executed e attending physician and for use as the burial - transi		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn	· —	aldeath 3	Ectopic preg	gnancy	23d. Date of deliver Month	y Day Year
Box 687 death certific the attending p	Physician/	1 Yes 2 No 9 V Unknow	Pregnant at time of dea	oth =	er (S <i>pecify</i>)				
that the denoted by the detached for		Part II. Other significant conditions		sulting in the un	derlying cause	given in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
S, P.O. uires that the n signed by Id be detach	ed by						-	2 ✓ No 3 Pro	
cords law requir has been	Completed			-			24a. Was a autops	sy prior to	utopsy findings available completion of cause of
tal Rectian: The certificate ector, page		25. Was case referred to medical			26 Dies	ce of Death (Chec	1 ✔ Yes 2		es 2 No
Vital ysiciar this cert	To Be		Hospital: 1 Inpatient 2 🗸	ER/Outpatient		Other:	sing Home 5 F	Residence 6 Othe	r:
n of ding Pt. After tuneral		27. Manner of Death	28a. Date of Injury (Month, Day Year) Nov 29, 2010	28b. Time of Inj 0200 hrs		ury at Work?		ow injury occurred n auto-fixed object	t collision caused
isio	icati	2 Accident Investigat	ion 28e Place of Injury - At ho			Yes 2 No	by another p	assenger treet and Number or Ru	iral Route Number City
Div pital or ours aft teral Di	Certification:	4 Homicide determine	De				or Town, St		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical (29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	ian: To the best of my knowledgor:On the basis of examination an	e, death occurre	ed at the time, o	date and place, a	nd due to the cause	e(s) and manner as stat	ed. e cause(s)
To To To Com	Med	29b. Signature and title of certifier	and manner stated.			se number		29d. Date signed (Mo	
		Carol H	Ellan		O.C	.M.E.		November 29, 20	
781		30. Name and address of person who Carol Allan, MD Assista	completed cause of death (Item 2 ant Medical Examiner	•	treet, Baltim	nore, MD 212	101		
St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signatur	bar	w				
ricgis	للتحد	V & EV							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 7.8 perFH, G910, 12720/2010, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 22, 2010 Mary I. Kravitz 7:30 PMM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7911 Robison Road Bethesda Montgomery 5. Social Security Number 8. Date of Birth 2/25/19 0. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Days Hours 1072571910 Director 100 99 Yrs. 489-09-6000 Poland Usual Residence of Decedent "natural", or items 23a or 28a-f show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No MD Montgomery Bethesda 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7911 Robison Road 20817 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ò Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White Completed 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Business Owner Women's Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isadore Seigal Fannie Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 showing permit. Page 1 and 2 showing perment of Health are Important: If item 27 is any injury or other trauonce. Eileen Beecher - daughter 7911 Robison Road Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 X Removal from State King David Mem Gardens 11/26/2010 Falls Church, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Md163 Edward Address of Facility Edward Sage Facility Pike Rockville MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Failure Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Advanced if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami signed by the attending physician and detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Bcx 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pothynidism 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 24 hours after death.

Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: ြု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No completed filled in by the ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 29b. Signature and title of contifier MD 069568 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

A Chilakamass

NOV 3 0 2010

1801 E Jefferson

2. Registrar's Sigr

Rockville, MD 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		For State Registrar	State of Maryl	-	eartment of Hea artificate of Dea		, ,	_ 20	10	39454
Physic	ian/	1. Decedent's Name (First, Middle, Last,)				2. Date of Dea		Year	3. Time of Death
Med Exam	ical	John H. Lee 4a. Facility Name (if not institution, give s	street and number)		4b. City, Town, or Loc	ation of Death	Novemb	er 20	2010	12:00 PM
		305 Old Steam Ship			Stevensvi	.11e		Queen		e's
Funera Directo			¥uo □ r I	rs. last birthday) Yrs.		Under 24 Hrs. ours Min.	8. Date of Birth 01/18/1	947		olace (State o <i>r Foreign</i> Fry) Ornia
Maryland 8a-f show tiffied at	rector	Usual Residence of Decedent 10a. State 10b. County Maryland Queen An	1	. City, Town or Lo					1	0d. Inside City Limits
vith the 1 23a or 2 ist be no	Funeral Director	10e. Street and Number 305 Old Steam Ship	Road		10f. Zip Code 21666			10g. Citizen of		· ·
DEBILLINOTE, IMARY/IBING 2.12.13-UU30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any once.	è	1 ☐ Never Married 2 🏋 Married	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates.		Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 2 🛣 No Se	exican, Puerto	cify Yes or No- Rican, etc.)	14. Rac	ce - Americ ck, White, e	an Indian, etc.
21Z13-UU36 vithin 72 hours after iene. r than "natural", o	Completed	15. Decedent's Edi (Specify only highest grace Elementary/Seconday (0-12)	ucation	16a. Dece (Give life. L	dent's Usual Occupation kind of work done during OO NOT use retired) crical Engin	g most of worki	ng	16b. Kind of B		dustry
yland	To Be	17. Father's Name (First, Middle, Last) John C. Lee		- 1			(First, Middle, N		e)	
Mar 2 shoul th and I 27 is m trauma		19a. Informant's Name/Relationship (Typ		1	ng Address (Street and N					1
nore, I		Mary Ruth Lee/Wife 20a. Method of Disposition 1 D Burial 2 X Cremation 3 D R	20 Removal from State	b. Place of Dispo cemetery, cre	osition (Name of matory or other place)		Date	20c. Location	- City or To	,
Baltimor permit. Page 1 Department of Important: If it any injury or o		4 Donation 5 Other (Specify) 21. Signature 1 February 2 February 2			ematory 2. Name and Address of 2.973 Solomon	FacilityGeor		alas Fu	neral	
cate be executed Examiner Physician and sthe burial-transit	1	23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):	ghermal	10	cm/2	Ly_	1	Approximate Interval Between Onset and Death
or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transition.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	3c. If yes, outcome of pre 1 ☐ Live Birth 2 ☐ I 4 ☐ Pregnant at time g ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				te of delive	ry Day Year
v requires that the speed by should be detailed.	Completed by Ph	Part II. Other significant conditions con Losten of Squam	ntributing to death but not			,	NO YE	es 2 🗆 No	3 🗌 Prob	e cause of death?
ician: The law certificate has bector, page 2 s		25. Was case referred to medical			26 Place o	f Death (Check	24a. Was ar autops perform	ned?	Were autop prior to con death?	sy findings available inpletion of cause of
hysician: his certifical	To Be	1 L Yes 212 No	ospital: 1 Inpatient 2		nt 3 DOA Other: 4		me 5 X Reside	nce 6 🗆 Othe	er (Specify)	
anding P eath. Pr: After t	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? M 1 Tyes		8d. Describe ho	w injury occurre	ed	
tral or Atterns after de al Directo	al Certif	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, str cify)	eet, factory, office	2	28f. Location (Str City or Town,		er or Rural i	Route Number,
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral directors.	Medical	(Check 2 Medical Examine only one) 3 Certifying Nurse	cian: To the best of my kn er: On the basis of examina Practioner: To the best of	ation and/or inves	tigation, in my opinion, de death occurred at the time	ath occurred at , date and place	the time, date and e, and due to the	d place, and due cause(s) and ma	to the caus	se(s) and manner stated. ted.
5 wit		29b. Signature and title of Certifier	1/20	2	29c. License num D31551	ber		9d. Date signed $11/22/2$		ay, Year)
10		30. Name and address of person who con Russell R. De Luca	305 Hospit	al Driv		nie. Ma	rvland '	21061		
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	barker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		4	For State	State of M	laryland /		tment of Healt		lental Hyg	jiene	ΕO	00155
	Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death											39455
Physic		n/	Wilbur Arnold					J	2. Date of Death Month November	Day	010	3. Time of Death 14:30 M
Med Exam	dica nine		4a. Facility Name (if not institution			4'	b. City, Town, or Locati		MOVEMBEL	4c. County		
2			Suburban Hosp				Bethesda	ı			ntgom	
Funera Directo		5	5. Social Security Number	6. Sex 7. Age 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ge (In yrs. last bir		If Under 1 Year If Undonths Days Hour	Inder 24 Hrs. urs Min.	8. Date of Birth (Month, Day, July 10,	Year)	9. Birth Cour	nplace (State or Foreign
		-	062-20-3065 Usual Residence of Decedent		83	Tro.			July 10.	1927	New	w Jersey
land show			10a. State 10b. County	ty	10c. City, Tov	own or Location	on					10d. Inside City Limits
Maryl 28a-f lotifie	4 1	irec		tgomery	No	orth_B	ethesda					1 ☐ Yes 2 🔀 No
th the 3a or the the n		a l	10e. Street and Number			1	10f. Zip Code		1	10g. Citizen of V	What Cour	intry?
ith witims 2	1	Funeral Director	5809 Nicholso			12 18/04	20852	2.0		USA		
sr dea or ite	i i	by Fu	11. Marital Status1 ☐ Never Married 2 ★ Ma	12. Was Decedent E Armed Forces? 1 X Yes 2	2	If Voc	s Decedent of Hispanic es, specify Cuban, Mexi	Origin? (Spec xican, Puerto f	cify Yes or No- Rican, etc.)		ce - Americ ck, White, e	ican Indian, , etc.
Use rs affer radia, lExar	=		3 Widowed 4 Divorce	1177	[№] 1946	1 🗆	Yes 2. No Spec	cify:		Specify:	,	hite
2 hour	3	Completed	15. Deced	dent's Education thest grade completed)	16	Sa. Decedent'	t's Usual Occupation of work done during m	t of worki		16b. Kind of Bu		
Lthin 77		ğΓ	Elementary/Seconday (0-12)) College (1-4 or 5		life. DO NO	IOT use retired)	nost of worm.	^{1g}			
ded with Hygie other ent, t		ط به	17. Father's Name (First, Middle,	5+		Civil	Engineer	1 - de Name				te Developme
be filental	1	입	Reuben Levent	,,				Mother's Name 'earl We	e (First, Middle, M. eisman	aiden Surname)	
ary hould and M is ma		-	19a. Informant's Name/Relations		15	9b. Mailing A	Address (Street and Nun			City or Town, S	State. Zip I	Codel
id 2 sl aalth a n 27 i		1	Steve Levente	r/Son	11	10625	Morning F	ield D	rive, Pc	otomac,	Mary	yland 20854
or oth		2	20a. Method of Disposition	on 3 Removal from State	20b. Place of cemet	e of Disposition etery, cremator	on (Name of ory or other place)	D	Date 2	20c. Location -	City or To	own, State
Ellin		L	4 Donation 5 Other ((Specify)		an Memo	orial Grds.			Olney,		,
Egitimore, Maryland 21213-0036 Jermit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ouce.	2	21. Signature of Funeral Service	e Licensee	$\alpha = \alpha$		ame and Address of Fac					
V-	1	+	23a. Part 1. Enter the disease, or			-	91 Rockvill				laryı	
Physician			Immediate Cause (Final	t only one cause on each line.	ne.	1						Approximate Interval Between Onset and Death
Physician Medica	al	0	disease or condition resulting in death)	a. Sche Due to (or as a	a consequence		art d	usea	14		+	Unset and pour.
Examine			listana	acut		enal	1 ins	info	ce cienc			10 days
- ±	اً و	₽	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as ε	a consequence		- C	1. 10	<u></u>	9		1
cate be executed physician and sthe burial-transit	edical Examiner	Xan.	Cause (Disease or linjury that initiated events	C. CLUH	2 1	iver	74	lure	<u>-</u>			10 days
be exe	1 5	<u>v</u>	resulting in death) Last	Due to (or as a	a consequence	of):						L
				d							_	
that the death certificate by that the attending physical by the attending physical editached for use as the the the the the the the the the the	2	IF 2	F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o						23d. Dat	te of delive	
Jeath Jeath Jeatte	Physician/M	١	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 4 Pregnant at			topic pregnancy her (specify)			Mon Mon		ery Day Year
t the c lby th	۶ ک	έĻ	g 🗌 Unknown	9 Unknown	195-				-			
ss that signed be dk	>	3	Part II. Other significant condition	tions contributing to death bu		in the under	ying cause given in Pa	art I.		,		he cause of death?
equire	atec	1	WI KITIS C.) Come					1			bably 4 🗆 Unknown
law r has b	Completed by	<u> </u>							24a. Was an autopsy	y pr	prior to com	psy findings available mpletion of cause of
n. The ficate or, pag			25. Was case referred to medical						performe		leath?	2 🗆 No
siciar s certi	To Be		examiner? 1 \(\sum \) Yes \(2 \) No	Hospital:	· ^ □ ED/C		Other	Death (Check o				
g Phy er this neral c			27. Manper of Death	28a. Date of injury		. Time of	28c. Injury at		ne 5 Residen			
ath. or: Aft. he fur	fica,	1 2		ling (Month, Day, tigation		injury M	work?	- 1	ia. Doct.	Trijury C.	1	
lation Attending Physician: The law requires rs after death. In Director: After this certificate has been signed in by the funeral director, page 2 should by	Certificate:	5	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be		arm, street, fr			28f. Location (Stree		r or Rural	Route Number,
ital or urs af ral Di									City or Town, S			
Hosp 24 hoi Fune eted f	Medical	29	(Ollect 2 Medical E	g Physician: To the best of m Examiner: On the basis of exa	xamination and/o	or investigation	on, in my obinion, death	n occurred at th	the time date and i	nlace and due t	to the caus	reals) and manner stated
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Σ		only one) 3 Certifying 9b. Signature and title of certifier	ig Nurse Practioner: to the b	pest of my knowled	/ledge, death	29c. License number	date and place,	e, and due to the ca	cause(s) and man	nner as stat	ated.
30			▶ Lheur A	Brinst	20	,	D 569		200	9d. Date signed (/	
		30	0. Name and address of person v	who completed cause of de	eath (Item 23a) /	/Tvoe, Print)	V 0 4 .	e j		lay	4/10	20016
-			Helen Sophi	ie Barold, M.I			ssachusett	s Aven	me Suit	e 202,	Wash	
Sta Registr	ate		1. Date filed (Month, Day, Year)		ar's Signature	harts	Ø.					0-
	- 22.T.	4	MARKET 18 11 41	HIII FA Buch	4 (2)	A STATE OF THE PARTY OF THE PAR	, affil 1					

-EVENTER, WILBUR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 39456 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November Brody Howard 2010 Lewis Medical 6:27 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PENINSULA REGIONAL MEDICAL WICOMICO SALISBURY 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Days Hours 2 0571472008 **Director** 217-81-9211 Maryland Usual Residence of Decedent show 10a. State 10b. County with the Maryland at 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f Maryland Wicomico Salisburv 1 X Yes 2 No 10e. Street and Number 10f. Zip Code er than "natural", or items 23a of the Medical Examiner must be 10g. Citizen of What Country? Funeral 431 Monticello Ave. 21801 USA be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) na nla nla injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ဂ္ Brad H. Lewis Casie Whetzel permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Casie Whetzel/mother 431 Monticello Ave., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Parsons Cemetery 4 Donation 5 Other (Specify) 11/26/2010 Salisbury, MD 21. Signature of Funeral Service Licenses ²² Name and Address of Facility HOILOWay Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ACUTE RESPIRATORY PAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CHRONIC (CENTRAL NERVOUS SYSTEM) 2 Y105 Seque tially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): FAIURF Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events ABNORMAUTES CONGENITAL Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OBSTRUCTIVE SLEEP APNEL, SLEEP RELATED 1 Yes 2 No 3 Probably 4 Unknown Completed VESICOURFERNIZ4a. Was an 24b. Were autopsy findings available prior to completion of cause of death? HYPOXEMIA, YENTILATOR DEP (LINCE BIIZTH) has r this certificate haral director, page RELUX EXTENSIVE LOSS OF WHITE MATTER E CORTICAL ATROPHY 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funeral 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗌 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only or 29b. Signature a title of certifier 29d. Date signed (Month, Day, Year) 58755 Nov 29, 2010 d address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

NOV

32. Registrar's Signature

Jenn K. Arzadon, MD 9714 HEALTHWAY DEIVE/BERUN, MD 21811

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			For State Registrar	State of Marylar		artment of He <i>tificate of D</i> e		-	giene Reg. No.	10	39457
	Physicia	an/	1. Decedent's Name (First, Middle, La	,				2. Date of De Month	ath Dav	Year	3. Time of Death
	Medi Examir	cal	Phyllis Jua 4a. Facility Name (if not institution, give	anita Myers ve street and number)		4b. City, Town, or L	ocation of Death	Novemb	<u>er 29,</u>	2010 unty of Death	9:12 A M
			13032 Ingleside			Belts				-	eorge's
	Funeral Director			Sex 7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird Sep 1	th	9. Birth	nplace (State or Foreign ntry) .Chigan
	land show dat	Ļ	Usual Residence of Decedent 10a. State 10b. County	100 0	ty, Town or Loc	oction		1005		1	
	farylar Ba-fsk tified a	Funeral Director		George's		Beltsville	2				10d. Inside City Limits 1 Yes 2 No
	a or 28 be not	直	10e. Street and Number	555_95 2		10f. Zip Code			10g. Citizen	of What Cou	
	ms 23 must	nerg	13032 Ingleside			207			Unite	d Stat	es
920	e filed within 72 hours after death with the Maryland trai Hygiene. ad other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Married	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2X No If Yes, Give Year or Dates.	If	√as Decedent of Hisp Yes, specify Cuban, ☐ Yes 2 XNo	Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White,	etc.
2-0	2 hour "natur idical	plete	15. Decedent's (Specify only highest g	Education		ent's Usual Occupati			16b. Kind o	of Business Ir	
Maryland 21215-0036	ithin 72 ene. • than '	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DC	ind of work done dur NOT use retired)		ang			
מ	불충수등	Be	17. Father's Name (First, Middle, Last)		Data	a Processo	8. Mother's Nam	e (First, Middle,		Gover	nment
ylar	should be fill and Mental some and Mental some second some second	은	Joh Wagr	er			Oliv				
Mar	of and 2 should be of Health and Ment fitem 27 is marker rother traumatic e		19a. Informant's Name/Relationship (** * *		g Address (Street and					
σĵ	1 and 2 soft Health item 27 other tra		Donna Farnsworth 20a. Method of Disposition	20b. F	Place of Dispos	Ingleside		Beltsv:		Maryla on - City or T	
<u>E</u>	Page ment c ant: If ury or	8	1 ☐ Burial 2 ☐XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec			atory or other place) ney Cremat				•	
Baltimore,	permit. Page 1: Department of I Important: If its any injury or ot once.	ľ	21. Signature of Funeral Service Licer	asee	Gc	Name and Address	Crematio	on Servi	ice P.). Box	784
	42 2.0 0		23a. Pard. Enter the disease, or con	M00	95/ BE	everry L.	Heckrot	<u>te, P.A.</u>	<u>. Ciari</u>	ksvill	e, MD 21029
P	hysician/ Medical		shoot, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. Seizures		the mode of dying,	sucii as calulac (or respiratory air	est,		Approximate Interval Between Onset and Death Weeks
	Examiner		f a sum of the sum of	Due to (or as a consequence Bronchopneum	•						2 weeks
	+	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ							z weeks
	and and I-transi	xan	Cause (Disease or linjury that initiated events resulting in death) Last	c. Lung Cancer Due to (or as a consequ							1 yr/10month
00/	atti certificate be executed attending physician and for use as the burial-transit	edical Examiner		d Brain Metas	,						1 yr/ 10month
02/20	ing phe as the		IF FEMALE:								
Hospital of Attending Physician The Journal of Attending Physician The Journal of Attending Physician The Journal of Attending the Attending The Journal of Attending the Attending The Journal of A	the attend	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	ıl death 3 🗌	Ectopic pregnancy Other (specify)				Date of deliv Month	ery Day Year
5	been signed by the should be detached		Part II. Other significant conditions of	ontributing to death but not resi	ulting in the un-	derlying cause given	in Part I.	23e. Did to	bacco use co	entribute to th	ne cause of death?
ds,	en sig	ted	Low grade Lym	iphoma				1 🗆 Y	′es 2□ No	3 🔀 Pro	oably 4 🗆 Unknown
records,	has be	Completed by	Prior History o	of Breast Cance	r			24a. Was a autop	sy	prior to co	osy findings available mpletion of cause of
֡֞֞֞֜֞֞֓֞֞֜֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֓֓֡֓֜֜֡֓֓֡֓֡֓֡֓֜֡֡֓֡֓֡֡֡֡֓֡֡֡֡֡֡	ificate ha		Chronic Bronchi 25. Was case referred to medical	tis		OC Disease		1 Yes		death?	2 🗆 No
VIC	r this certificate haral director, page	To Be	examiner? 1 □ Yes 2 🙀 No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient	Othor	of Death (Check		ence 6 \square O	ther (Specify	1
5	After th		27. Manner of Death 1 ✓ Natural 5 ☐ Pending		28b. Time of injury	28c. Injury at work?		28d. Describe ho			,
IVISION	ctor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	De 280 Place of Injuny - At hor	me farm stree		3 2 □ No	Oof Leasting (Ct		-h	D. A. M. A.
	2 A control of the co	- S	4 ☐ Homicide determined	building, etc. (Specify))	is, factory, office		28f. Location (St City or Towr		nber or Hurai	Houte Number,
Hoeni	within 24 hours after To the Funeral Dire completed filled in b	Medical	29a. Certifier 1 Certifying Phy (Check 2 Medical Exam	sician: To the best of my knowle iner: On the basis of examination	edge, death oc and/or investig	cured at the time, da	te and place, and	d due to the caus	se(s) and mai	ner as state	d.
dit o	ithin 2 o the l	M	only one) 3 Certifying Nur 29b. Signature and tive of certifie	se Practioner: To the best of my	knowledge, de	ath occurred at the tir	ne, date and place	e, and due to the	cause(s) and	manner as sta	ated.
	> = 0		1/2				3139		9d. Date sigr	29	12010
3	,		30. Name and address of person who						/		/ / -
<i>-</i>		_	Sita Krishnamoor 31. Date filed (Month, Day, Year)	thy, M.D. 12201	Plum	Orchard D	rive Sil	ver Spr	ing, M	arylar	nd 20904
	State Registra		31. Date filed (Month, Day, Year)	110 January Solghall	R L						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Α. Frank McHenry, Jr. November 2010 Medical 6:45 A 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1700 Fletchers Drive Point of Rocks Frederick 5. Social Security Numbe 7. Age (In vrs. last birthdav) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Auq 1, 1945 **Funeral** 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Months Hours New Jersey Director Yrs. 146-36-7190 65 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick Point of Rocks 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1700 Fletchers Drive 21777 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 X Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Kitchen Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frank A. McHenry, Sr. Corolyn В. Meyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tara A. Forgette/daughter 1700 Fletchers Drive Point of Rocks, MD 21777 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 12/3/2010 Woodbine, Maryland 21. Sign the of Funeral Service Lice Going Home Cremation Service P.O. Box 784 unnita M00957 Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final +hysician/ Onset and Death disease or condition resulting in death) Asystole Minutes Medical Due to (or as a consequence of): Examiner Hypoxia Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Hours Examine Due to (or as a consequence on. requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Hypopnea Narcosis signed by the attending physician and I be detached for use as the burial-tran Days Due to (or as a consequence of) Physician/Medical Encephalopathy Davs 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Small Cell Lung Cancer Extensive Stage 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 🗌 No Yes 2 🔀 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ည 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No Accident Investigation 6 Could not be

Division of Vital Records, P.O. Box 68760 After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed

file

State Registrar

Medical

Suicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DEC

determined

4 Homicide

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

2 Medical Examiner: On the basis or examination and a supersistence of the basis of my knowledge, de Certifying Nurse Practioner: To the bast of my knowledge, de

Thomas Johnson Drive

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

ath occurred at the time, date and place, and due to the cause(s) and manner as stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 29, 2010 November 10:30 a Marni Leigh McNeese Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Columbia Howard 7218 Lasting Light Way Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) Funeral Days Min 1 □ M 2 F Year 951 202-42-0647 59 June 7, Director Yrs CA Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7218 Lasting Light Way 21045 USA ed other than "natural", or items event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 2 X No Completed by 1 Yes If Yes, Give 1 ☐ Yes XX No Specify: 3 Widowed 4 Divorced White Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, Elementary/Seconday (0-12) Social Worker Social Work Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Marjorie J. Leverenz John R. McNeese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important If item 27 is any injury or other trains Brother J. Michael McNeese 2416 Fairway Oaks Ct. Hampstead, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)
Ardent Cremation Ser. 12/4/2010 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facil Harry H. Witzke Family FH, 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ History of Cardiomyopathy (Heart Failure) disease or condition Medical resulting in death) Examiner History of Liver Failure s/p Liver transplant Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 No the 9 Nuknown 9 Unknown is been signed by tl 2 should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available 24a. Was an has e 2 autopsy prior to completion of cause of certificate 1 Yes 2 No Yes 2000 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 🔀 No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

le Funeral Director: Aft
bleted filled in by the fur 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 🛚 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, uearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

Dou Alvin Zhang

31. Date filed (Month

DouZlee

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 N. Charles St.

32. Registrar's Signature

S. S. A. C.

D0066903

30/10

Ste 615 Pavilion East Baltimore, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 03 UM ELYN 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Edgewater 1260 Beach Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 X Days 69 218-38-8932 (Month, Day, Year) Ny NY Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Machine. 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Edgewater 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1260 Beach Road 21037 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2X No Specify. 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working fe_DO NOT use retired) Homemaker Elementary (Seconday (0-12) College (1-4 or 5+) Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ John Parham Elsie Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick Menage Spouse 1260 Beach Road Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 11/18/2010 Atlantic Crematory Glen Burnie, MD 21. Signature of Funeral Vervice Licenses 22. Name and Address of Facility 12 Ridgely Ave Hardesty Funeral Home P.A. at Annapolis, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): nding physician a use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) 1 ☐ Live Birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Sesidence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No hours after death Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie me and address of person w d cause of death (Item 23a) (Type, Print) 31. Date filed (Month. Day. 32. Reg State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 20,2010 Thelma Phebe Murray 6:15 a[™] Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Marley Neck Health And Rehab <u>Glen Burnie</u> <u>Anne Arundel</u> 5. Social Security Numbe 8. Date of Birth **Funeral** 7. Age (In yrs. 9. Birthplace (State or Foreign 1 M 2 X F Months Hours Min. 74 097-28-8360 0670271936 Director Beacon NY Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Severn 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 883 Maple Tree Road 21144 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ▼ No If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation المالية المال 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u> Assistant</u> Dental Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Risk Kenneth Sheldon Eddy Almedia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy Davis Daughter 883 Maple Tree Road Severn, MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State St. Peters Cemetery 11/27/2010 Poughkeepsie, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Sune al Service Licenses 22. Name and Address of Facility 851 Annapolis Road Gambrills, MD 21054 Date Hardesty Funeral Home P.A. 23a. Part 1. Enter tile disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last burial Physician/Medical that the death certificate be the. IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has ; page 2 s performed certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☐ No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation Accident 1 Yes 2 No 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 30 6 41

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

NOV 2 2 2010

68760

Box (

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ramch Schapalin 201-107 ISack Never neck Nord

November

21221

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year DOROTHY 1725 11 10 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE OF MARYLAND UNIVERSITY MEDICAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8 Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X** F Months DEC. 9. Director 220-32-5909 78 1931 WASHINGTON, D.C. Usual Besidence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f shoi ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 No MARYLAND TALBOT **EASTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 38 PARK LANE 21601 UNITED STATES 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRACTICAL NURSE **HEALTH CARE** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) RALPH A. TURNER DOROTHEA V. DIXON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROY MCALLISTER/SON 6325 NAVAL AVENUE, LANHAM, MARYLAND 20706 Important: If Item 2 any Injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date CHESAPEAKE⁷ CREMATION CENTER 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Livensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) IBARACHNO ID Medical Due to (or as a consequence of): **Examiner** Secure tinib list over litter w if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami The law requires that the death certificate be executed Cause (Disease or linjury ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records. P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Dav g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 XYes 2 □ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certified 29c. License number P25666 MD 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERK OF MARYLAND MEDILAL CENTER BALTIMORE, MI). MARTIN MD UNIVERSITY

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year,

NOV 30

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert Coad Moore Month Medical December 2010 4:50 A Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Asbury-Solomons Health Care Center Solomons Calvert Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Days 1 X M 2 □ Months Director Hours Min. 03-08-1922 578-26-5297 Washington, DC 88 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Me it al Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Calvert Solomons 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with 11521 Emmanuel Way, #533 20688 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ģ 1 Never Married 2 Married Black, White, etc. Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Completed 3 X Widowed 4 ☐ Divorced White Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other th 12 General Superintendent Commerical Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Leonard Moore, Sr. Eleanor Coad 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Thomas C. Moore - Son 735 Larue Road, Millersville, Maryland 21108 item Baltimore, 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place Metropolitan Crematory 12-1-2010 Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition TEMSIVE Medical resulting in death) Due to to as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that the death certificate be executed OCYTEMSION and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Pregnant at time of death ☐ Yes 2 ☐ No Month Day Year detached 9 Unknown g Unknown à been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician; The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 ☐ Yes 2 🗷 No Yes 2 KN 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) မ Other: After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) in by the funeral 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1-Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident after death Investigation □ Accider □ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D47610 December 1, 2010 evely

Registrar
DHMH 17 Rev 7/2009

State

David J. Tardio, MD 110 Hospital Road, Suite 310, Prince Frederick, Maryland 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010▶

32. Registra s Signature

31. Date filed (Month, Day, Year,

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 29,2016 Lee Raymond Minin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Calvert County Nursing Center Prince Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 월 M 2 □ F Hours. 04/04/193 170-24-7728 Director 79 Usual Residence of Decedent 28a-f show 10a. State 10b. County an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10c. City. Town or Location Director Maryland Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13405 Lore Pines Lane 20688 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) the Deputy Program Manager U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked of ပ Emma Jane Borland John Abraham Minin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau P.O. Box 998, Solomons, MD 20688 April joyce Minin / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🛱 Burial 2 🗆 Cremation 3 🗆 Removal from State Franklin Cemetery 12/04/2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee P.O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician the buria Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy nse 23b. Was decedent pregnant ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) ____ for in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown P.0. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Cancer 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an page 2 s performe Yes 2 No 25. Was case referred to medical of Vital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred in 24 hours after death.
the Funeral Director: After apleted filled in by the funer 1 Natural 2 Accident 5 Pending Division 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certify

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

11:56 AM

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 Yes 2 K No

Pennsyl<u>vania</u>

14. Race - American Indian,

Black, White, etc.

Specify: White

Franklin, PA

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 🗆 No

Month

Calvert

State

Registrar DHMH 17 Rev 7/2009 pleted cause of death (Item 23a) (Type, Print)

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 11/29/2010 **Physician** Eileen Conboy McCarthy 11:43 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester 5. Social Security Number 7. Age (In vrs. last birthdav) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 86 **Director** 087**-**18-5850 2/10/1924 NY Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location init. Pages 1 and 2 should be filed within 72 hours after death with the Marylar cartment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Winward Court 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2★☐ No 2 Specify Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Conboy Catherine Fardy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2309 Eccleston St., Silver Spring, MD 20902 Shristine Beane/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) John Evangelist 12/6/2010 Silverspring, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician utenne Canc ! /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Injury at Work? Hospital or Attending 24 hours after death. 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Merical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) りとろして MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Rrint) Healthway Dr Berlin MD 21911 9733 Sairc 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

DEC 0 1

Maryland 21215-0036

Baltimore,

Records, P.O.

Vital

0

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HOTTA M. MANJA NOVEMBER 26. 2010 0027 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FORT WASHINGTON MEDICAL CENTER PRINCE GEORGES FORT WASHINGTON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😾 F Hours JANUARY 9. **Director** 69 Yrs. 215–37–9902 1941 SIERRA LEONE Usual Residence of Decedent 28a-f show 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director MARYLAND PRINCE GEORGES FORT WASHINGTON 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1908 ARROWOOD COURT 20744 SIERRA LEONE, WEST AFRICA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 ☐ Yes 2 ☐ No þ Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes ⊿ If Yes, Give 1 Yes 2 No Specify: Completed 3X Widowed 4 ☐ Divorced Specify: AFRICAN Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation e filed wiu. *عا Hygiene. *ع**r than "**P 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEWIFE HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ MENDAGLIE BOUDAY FENDA MENIA BOUDAY 2 should better and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau FODAY H. MANJA / GRANDSON 1908 ARROWOOD COURT, FORT WASHINGTON, MARYLAND 20744 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State MANJA FAMILY CEMETERY DEC. 14, 2010 BUEDU, SIERRA LEONE 4 ☐ Donation 5 ☐ Other (Specify) ture of Funeral-Service Licensee THORNTON FUNERAL HOME, PA 3439 LIVINGSION ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNTON JOHNSON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box (in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by)isordy Records, 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page performed? Yes 2 X No 1 Tyes **Division of Vital** director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No ည 1 Inpatient 2 K ER/Outpatient 3 DOA 27. Manner of Death 1 Natural To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Thysician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar ARASTOO YAZDANJ M.D. 49135 PISCATAWAY ROAD, SUITE 235, CLINTON, MARYLAND 20735 Registrar's Signature

29c. License number

D0050454

29d. Date signed (Month, Day, Year)

NOVEMBER 30, 2010

DHMH 17 Rev 7/2009

certifier

29b. Signature and title of

30. Name and address of person who

f death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	The state of the s
Rhonda Jane Minnick	State of Maryland / Department of Health and Mental Hygiene
1- For State	Certificate of Death

		Registrar			Certino	ale oi	Deam	<u>'</u>				Reg. N	0		
Physic Medical Exam			ane Minnick							1	2. Date of De Month Novemb		, 2010 Year		3. Time of Death 0445 hrs
		4a. Facility Name (if not institution Southern Maryland Ho	_	number)		4	4b. City, To Clintor		ocation o	of Death		ľ	4c. County o Prince G		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last bir	thday)	If Under	1 Year	If Under	r 24Hrs.	8. Date of I	Birth (Mi	W/DD/YYYY)	9. Bir	thplace (State or
Director		226 86 5551	1 M 2XX		55	Yrs.	Months	Days	Hours		March			Foreig	n untry) Virginia
-		Usual Residence of Decedent		1		115.	·	<u> </u>	L			,		00	unity) VIIghha
any		10a. State 10b. County		10	c. City, Town	or Locati	ion			_					10d. Inside City Limits
* .		Mary 1 and Desimon	Casassia												1 Yes 2 XX No
rland -f.sh	ğ		George's		<u> </u>	lintor									
Mary - 28a ed at	Director	10e. Street and Number	D.:				10f. Zip C						itizen of Wh		•
3a ou	□	6303 Den 1ee	Drive					20735				1	United	Stat	es
thours after death with the Maryland "natural", or items 23a or 28a-f show Examiner must be notified at once.	Funeral	11. Mantal Status	12. Was De		er in U.S.						cify Yes or N	lo-			can Indian, Black,
death r ite	Š	1 Never Married 2 M	arried 1 Yes	Forces?	No	If Ye	es, specify	Cuban, I	Mexican,	Puerto R	ican, etc.)		White,	etc.	
ther ult. o	by F	3 Widowed 4 Div	orced If Yes, Give Y		1 110	1	Yes 2	No No	specify:				Specify:	T _A	hite
ours a	a b	15. Decedent's Education (Spe-	or Dates: cify only highest gra	ade comple			t's Usual O					16b.	. Kind of Bus	_	
72 ho	Completed	Elementary/Secondary (0-12)	College	(1-4 or 5+)		during mo	ost of worki	ng life. D	O NOT u	use retire	d)				
D36 thin	ם	12	4			Regul	lation	Spec:	ialis	t			EPA		
od wi	5	17. Father's Name (First, Middle,	Last)					18	.Mother's	s Name (F	irst, Middle	Maide	n Surname)		
215 e file tal H ked e	Be (Nathan Minni	ck								Pannell				
212 uld b Men marl	10 E	19a. Informant's Name/Relations	hip (Type, Print)		198	o. Mailing	Address	(Street a					City or Town	State	Zin Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Departmet of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	-	James D. Gaunt (S									n, MD 2			, Otato,	Zip code;
and and lealth tem trau		20a. Method of Disposition	1		20b. Place of				-		Date		Location - 0	City or	Town State
Ore ges 1 of H		1 Burial 2 K Cremation	3 Removal	from State	cremate	ory or oth	er place)								· o····, o·to·to
Lim Pagentant		4 Donation 5 Other Sp			Lee C						3, 2010		linton,		
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		21. Signature of Funeral Service	Licensee	MO	153	22. Na	ame and A	ddress o	f Facility]	Lee Fr	uneral :	Home	Inc 66	33 0	ld Alexandria
	1-3	mula 14.	24-		>	rei	rry koa	ad, C	Lintor	n, MD	20/35				
Physician													Approximate Interval Between Onset and		
/Medical Examiner		Immediate Cause (Final disease a. Pulmonary Thromboembolism complicating Morbid Obesity											Death		
		or condition resulting in death)	Due to (or as	a consequ	ence of):										
		Sequentially list conditions,	b												
	Examine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequ	ence of):										
	am	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence of):							_		-	
uted nd ransit		3 ,	d.												
68760, certificate be executed nding physician and ise as the burial - transi	an/Medical	UNPENDED	AMENDED										-		
60, ate be hysic e bur	Nec	IF FEMALE:	23c. If ves.	outcome i	of pregnancy							1 23	Bd. Date of d	eliveor	
68760, ertificate b ding physic e as the bu	l/u	23b. Was decedent pregnant in the past 12 months?	e 1 Live		2	Feta	al death	3	Ectopic p	pregnanc	у	'`	Month	,	ay Year
X 6	ici	<u>,</u>	4 Preg	nant at tim	e of death 5		er (Specify)							
Box e death c the atten ed for us	Physicia	1 Yes 2 No 9 V Unk	9 Onki												
P.O. Box 6 so that the death cer gned by the attendil e detached for use a		Part II. Other significant conditi	ons contributing t	to death bu	t not resulting	in the un	nderlying ca	use give	en in Part	t I.					ne cause of death?
ires the signe	d by										1 Ye	s 2	No3	Proba	ably 4 🗹 Unknown
Division of Vital Records, Fial or Attending Physician: The law requires its after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed										24a. Was		24b. W	ere auto	opsy findings available
CO e law e has	E G		-							_	auto perfo	rmed?		or to co ath?	impletion of cause of
Rec : The ificate		05.14									1 ✓ Yes	21	No 1	Yes	2 No
ician icerti	Be	25. Was case referred to medical examiner?	Hospital:					104	hor: C	Check onl					
Phys.	ဥ	1 ✓ Yes 2 No			2 V ER/Ou			<u> </u>	٠ ــــــ ٠		lome 5			Other:	
Affe	ü	27. Manner of Death 1 ✓ Natural 5 □ Road		of Injury h, Day,Year)	286. 1	ime of Inj	ury 28c		at Work?	- 1	d. Describe	how inj	ury occurred		
tteno death ctor:	aţį	Penal	ing tigation				1	Yes	2 N	1 0					
ivis or A after Direction by	ij.		not be	ce of Injury	- At home, far	rm, street,	, factory, of	fice build	ling, etc.	28	f. Location (or Town,		and Number	or Rura	al Route Number, City
Division of Vital ipital or Attending Physician: iours after death. neral Director: After this certifi	Certification:	4 Homicide	mined (Specify)								OF TOWIT, A	otate)			
Hos 24 h Fun etely		29a. Certifier 1 Certifying Ph	ysician: To the be	st of my kn	owledge, dea	th occurre	ed at the tin	ne, date	and place	e, and du	e to the cau	se(s) ar	nd manner a	s stated	1.
Division of Vital Records, P.O. Box within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death. To the Funeral Director: After this certificate has been signed by the attent ormpletely filled in by the funeral director, page 2 should be detached for u	Medical	опе) 2 Medical Exam	niner:On the basis and manner:	of examina	ation and/or in	vestigatio	on, in my op	oinion, de	eath occu	urred at th	e time, date	and pla	ace, and due	to the	cause(s)
L & F &	ž	29b. Signature and title of certifier					29c. Li	icense n	umber			29d.	Date signed	(Mont	h, Day, Year)
		and	The state of the s				c	C.M.I	E.			Nov	vember 2	2, 201	10
_	-	30. Name and address of person	who completed cau	se of death	n (Item 23a)						_	1			
234			istant Medical			enn St	reet, Bal	timore	, MD 2	1201					
	ate	31. Date filed (Month, Day Year)	32 R	egistrar's S	ignaty r e	bark	, ,				-				
		MOV OG		un	M	30 M L	ALCO VI								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ A M aur 010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Shady Grove Adventist Hospital Date of Day, Yea, (Month, Day, Yea, 9. Birthplace (State or Foreign . Social Security Number 6. Sex 1 A 2 ⋅ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours 42 Oh i.o 285-66-5057 Yrs. 1968 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1X Yes 2 ☐ No Montgomery Germantown MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be ginee. Funeral USA 20874 <u>2411 Port Haven Drive</u> Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 K Married þ 1 Yes If Yes, Give 2 🔀 No Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) History Association Archivist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Barbara Morse Dieter Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12411 Port Haven Drive, Germantown, Maryland 20874 Cynthia Myers/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 S Cremation 3 Removal from State Falls Church, Virginia 4 Donation 5 Other (Specify) 11/26/2010 National Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityEdward Sagel Funeral Direction M0159 MCGreenhat 1091 Rockville PIke, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on eight line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list canditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performe 1 Yes 2 No 25. Was case referred to medical examiner?
Yes 2 \(\subseteq \text{No} \) Division of Vital 26. Place of Death (Check only one) Be Other: 1 Inpatient 2 ER/Outpatient_3 DOA ည 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 ☐ Yes 2 ☐ No Accident Investigation in 24 hours the Funeral Dires. Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Octifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2

To the I

complete Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) enter Dr. Lockville 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra AMEND#27perMD11/30/10, EMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ - 25 - 2010 Month 7:03am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Heart Home Annapolis Anne Arundel 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sept . 26, 1945 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 € M 2 □ F Days Director Mary land 217-44-4396 65 Yrs. Usual Residence of Decedent 28a-f show 10a State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Maryland St. Mary's Mechanicsville 1 ☐ Yes 2 X No Ö 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? Funeral 38195 New Market Turner Road or items 23a 20659 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 No Specify: White Completed 3 Widowed 4X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Service Mechanic HVHC Local #602 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank E. Manuel Erma Elizabeth Ayton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38195 New Market Turner Road Mechanicsville, Maryland 20659 Paula Murdock -daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State St. Johns Episcopal Ch. Cen. 11/30/2010 Beltsville, Maryland 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Licenses Dönald V. Bolgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Jest Millen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Advanced Physician/ disease or condition resulting in death) lars Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) fransit Transit Cause (Disease or iinjury that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No ò Month Dav Year signed by the af d be detached for 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Onknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed Yes 2 certificate 2 🗆 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be the funeral director 26. Place of Death (Check only one) assiste Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Spec 은 1 Tyes 2 E 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Peath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Jural injury work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. Investigation 6 Could not be 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ompleted filled in by determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, To the I within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only Ine Sign 29d. Date signed (Month, Day, Year)

1/ - 26 - 2 CV 0 1 50725 MD Parstluy M. Versulle MD 21108 completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

P.O.

Division of Vital

			Type or Pri				c. Ensure A lealth and N	-	_	ole.	•
	•	1 - For State Registrar	Otato of Mil	ar yraina /		tificate of E			g. No. 1	0 201	7.0
Dhysisis	-/	1. Decedent's Name (First, Middle, La	,					2. Date of Death	1.01	3. Time of	Death
Physicia Medic			ertrude D.	Machli	in			Month 9	1-2010	ear 3:55	AM
Examin	er	4a. Facility Name (if not institution, give					Location of Death		4c. County of		
5		Renaissance Gard 5. Social Security Number 6. S		rwood e (In yrs. last b	oirth doul	If Under 1 Year	lver Spr If Under 24 Hrs.	ing 8. Date of Birth		ce George	
Funeral Director			☐ M 2 🗓 F	91	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 12/29/	7918	Birthplace (State of Country) Michie	r Foreign LGan
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 29a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	tor	10a. State 10b. County		10c. City, To	wn or Loc	ation				10d. Inside Ci	ity Limits
Mary 28a-f	Director		George's				lver Spr	ing		1 🗆 Yes	2 🛭 No
th the		10e. Street and Number				10f. Zip Code		10	Og. Citizen of Wha		
ath wi	Funeral	3160 Gracef	Leld Road 12. Was Decedent E	vor in LLS	13 14	as Decedent of Hi	20904 spanic Origin? (Spe	ocify Von or No	Lub	u.s.A.	***
or ite	by F	1 Never Married 2 Married	Armed Forces?	-	If	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		American Indian, White, etc.	
urs aft ural", al Exa	ted I	3 🕅 Widowed 4 🗌 Divorced	If Yes, Give Year or Dates.		1	☐ Yes 2 🛛 No	Specify:		Specify:	White	
72 ho "nat ledica	Completed	15. Decedent's E (Specify only highest gi		16	(Give ki		ation luring most of work	ing	6b. Kind of Busin	ness Industry	
/ithin iene. r thar the M	Con	Elementary/Seconday (0-12)	College (1-4 or 5-	+) B		NOT use retired) . Town.am	ent Direc	ctor	Enter	tainment	
illed vall Hyg I othe vent,	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam			oct or an erro	
ld be Menta arkec atic e	욘	Isado	re Drusin					Fannie	Rapkin		
shou n and 7 is m raum		19a. Informant's Name/Relationship (1					and Number or Rura				
and 2 Health em 2 ther t		Jack Machlin - 3	son			Thompso ition (Name of	n Road, S				
age 1 t: If it		1 X Burian 2 Cremation 5		ce <i>m</i> e	tery, crem	atory or other plac	e)		0c. Location - Ci		,
nit. Paratme ortan injur		4 Donation 5 Other (Speci 21. Signature of Euneral Service Licen			awn 1	Mem. Grdy	us of Facility Hill	0/2010 1	KOCKVILL Pdi Funo	le, Maryla ral Home,	Ind Inc
lmp any onc		Jan 1	nui NODT	07	11	800 New	Hampshire	2 Ave., S	silver S	pring, MD	20904
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused	the death. Do						Approximat Interval Bet	e
hysician/		Immediate Cause (Final disease or condition	a. Obst		e Jau	ndice				Onset and I	Death
Medical Examiner		resulting in death)	Due to (or as a	consequenc	e of):					- 11107	0.00
	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequenc	e off:						_
and I-transit	xaminer	cause. Enter Underlying Cause (Disease or iinjury	-	•	,						
× – a	ш	that initiated events resulting in death) Last	Due to (or as a	consequenc	e of):						
incate be ex ig physician as the burial	dica	•	d								
aur ceruicate be ex attending physician for use as the burial	Physician/Medical	IF FEMALE:	23c. If yes, outcome of	of pregnancy							
atten for us	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ※ No	1 Live Birth 4 Pregnant at	2 🔲 Fetal de		Ectopic pregnanc Other (specify)	у		23d. Date of Month		/ear
oy the achached	hysi	g Unknown	g 🗌 Unknown								
requires that the de- been signed by the should be detached	by P	Part II. Other significant conditions of	ontributing to death bu	ut not resultin	g in the un	derlying cause giv	en in Part I.	23e. Did toba	acco use contribu	ite to the cause of d	eath?
equires sen sigi ould be	Completed by	<u>Hypertension</u>						1 🗌 Yes	2 K No 3	☐ Probably 4 ☐ I	Unknown
law re nas be	nple							24a. Was an autopsy	prio	re autopsy findings a or to completion of c	available ause of
ician: me law sertificate has ector, page 2:								perform 1 Ves 2		th? Yes 2 No	
s certificate has be lirector, page 2 s	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:			Othe	ace of Death (Checker:				
eral d	e: To	27. Manner of Death	28a. Date of injur	ent 2 ER/9 y 285	. Time of	28c. Injury	at	ome 5 Residen		Specify)	
ath. rr: Afte	ficat	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigatio		Year)	injury	M 1 □	? Yes 2 □ No		,,		
Spital of Attending rives hours after death. neral Director: After this of filled in by the funeral director.	Certificate:	3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined	28e. Place of Injuit building, etc.	ry - At home, . (Specify)	farm, stree	et, factory, office		28f. Location (Stre City or Town,		r Rural Route Numb	er,
on the nospinal or Autentung ruysicans. within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Phy (Check 2 Medical Exam	sician: To the best of r iner: On the basis of ex	my knowledge	e, death od	ccured at the time,	date and place, an	d due to the cause	e(s) and manner a	as stated.	nner stated
thin 24	Me	only one) 3 Certifying Nur 29b. Signature and title of certifier	se Practioner: To the b	pest of my kno	wledge, de	eath occurred at the	time, date and plac	e, and due to the c	ause(s) and manne	er as stated.	iiio sidieu.
ID		Sillion I	Omemol	Dry	218	29c. License	Number 866		d. Date signed (M	ronth, Day, Year)	
*		30. Name and address of person who	completed cause of de	ath (Item 23a	Myne Pr		Jour	(0	12-11		

Registrar

State

				Ple					ndelible In		-		_	ie.	
			For State Registrar			State of	Marylan		artment of rtificate of		nd Mental	Hygien Reg. 1	201	0 39	471
	Physicia		Decedent's Name Decedent's Name		. ,	- M 17					2. Date o Month	f Death	Day Ye	ear	of Death
jen.	Medio Examir		4a. Facility Name (if			ye McKi		<u>.</u>	4b. City, Town, o	or Location of I		mber	26 26 26		18A M
man de		П	Doctor	_						Lanham				ce Geor	ge
	Funeral Director		5. Social Security Nu 578-64-	0020	6. Sex 1 🗀	M 2 🔀 F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days			, Day, Year	1949	. Birthplace (State Country) D	
	and show	ē	Usual Residence of 10a. State	10b. County	,		10c. Cit	y, Town or Lo	ocation					10d. Inside	City Limits
	Maryl 28a-f notifie	Director	Maryland		ce Ge	orge				Capito	l Height	s		1 🖼 ነ	res 2 🗌 No
	vith the 23a or st be r	ral	10e. Street and Num 5231 Ma		D-11c	o # 103)		10f. Zip Code	20743		10g. (Citizen of Wha		
	tems remu	Funeral	11. Marital Status	110010		. Was Decede	nt Ever in U.S	3. 13.	Was Decedent of H If Yes, specify Cub		? (Specify Yes or	No-	T	1 States American Indian,	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 X Never Marri 3 ☐ Widowed		- 1	Armed Force 1 Yes 2 If Yes, Give Year or Date:	⊠ No		If Yes, specify Cub		-uerto Rican, etc.)		Black, V Specify:	Vhite, etc. Black	
15-(72 hou n "nat ledica	Completed		15. Decede cify only high				(Give	dent's Usual Occu kind of work done	during most of	f working	16b.	Kind of Busin	ess Industry	
212	within giene. er tha		Elementary/Seco	onday (0-12) 2th		College (1-4	or 5+)		ONOT use retired		ssistant	:	Priva	ate	
and	be filed ental Hy ked oth ic event	To Be	17. Father's Name (F			36 77 1	-			18. Mother's	s Name (First, Mia		,		
aryla	should be file n and Mental H 7 is marked o raumatic eve	-	19a. Informant's Na			McKini	ney, S	_	na Addrona (Ctroot	and Number			arriso		
Σ,	id 2 sh salth ar n 27 is er trau		Hilda Fa				ughter		ng Address <i>(Street</i> - Lori St		Suitland	-		20746	
Baltimore, Maryland	ge 1 and nt of Heal s. If item or other		20a. Method of Disp 1 X Burial 2		3 ☐ Re	moval from St	20b. P	lace of Dispo	osition (Name of matory or other pla		Date	20c.	Location - Cit	y or Town, State	
Itim	permit. Page 1 Department of Important: If i any injury or once.		4 ☐ Donation 21. Signature of Fun			1			r Hill 2. Name and Addre	De of Facility	ec. 4,201	0 s		d, Maryl	
Ba	Dep Imp any	3	· Non	W >	1-1	Da	till	1/1/1	4001 Benr					me, Inc. 0019	•
~	Physician/		23a. Part 1 Enter the shock, or heart Immediate Cause (F	t failure. List i Final	complicationly one of	ause on each	line.							Approxim Interval B Onset and	etween
	Medical Examiner		disease or condition resulting in death)	1	a .	Due to (or	as a consequ	ence of):	Cardio	13	1000	Lure			
		er	Sequentially list cor	nditions,	b.		e Pseu as a consequ		branous	Colitis	S				
	uted d ansit	Examiner	cause. Enter Underl Cause (Disease or if that initiated events	lying injury	,		tridum		cile						
	be executed sician and burial-transit		resulting in death) L				as a consequ i-Syst	,	an Failu	re					
876	ifficate ng phy: as the	Medi	IF FEMALE:		- a.		-								_
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director, After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	23b. Was decedent print the past 12 mg 1 Yes 2 2 9 Unknown	nonths?	230	. If yes, outcor 1 Live Birl 4 Pregnar 9 Unknow	th 2 🗌 Feta It at time of d	Ideath 3	Ectopic pregnand Other (specify)	су		_	23d. Date of Month	delivery Day	Year
P.0	that the	by Pł	Part II. Other signific				h but not resu	ulting in the u	nderlying cause gi	ven in Part I.	23e. D	id tobacco	use contribut	e to the cause of	death?
rds,	v requires been sig should b	eted	Acute R			re					_ 1	☐ Yes 2	2 🖾 No 3 🗆	Probably 4	Unknown
Division of Vital Records, P.O.	The law n cate has b page 2 sh	Completed	Morbid	obesit	. у						_ p	/as an utopsy erformed? es 2. ☎ N	prior deatl	e autopsy findings to completion of n? Yes 2 \(\sum \) No	
ital	sician; certifii irector) Be	25. Was case referred examiner? 1 ☐ Yes 2 ☑		Hos	pital:			Oth	er: _	Check only one)				
of/	ng Phy ter this neral d	te: To	27. Manner of Death	5 Pendir		28a. Date of it	atient 2 🔲 I njury Day, Year)	28b. Time of injury	28c. Injur	y at	ng Home 5 R			pecify)	
ion	ttendir death. tor: Af the fu	Certificate:	2 Accident 3 Suicide	Investig	gation				M 1 🗆	Yes 2 No					
Sivis :	al or Ar s after I Directed in by		4 Homicide	determ	ined	building,	njury - At nor etc. (Specify)	me, farm, stre	eet, factory, office			n (Street ar Town, State		Rural Route Nun	nber,
_	To the hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 %	Medical	(Check 2 l	Medical E	xaminer:	On the basis o	f examination	and/or invest	occured at the time igation, in my opinion	on, death occur	red at the time, da	te and plan	e and due to t	he cause(s) and m	nanner stated.
	withi 70 th		29b. Signature and ti			,			29c. License			1		onth, Day, Year)	
			30. Name and address	- V	ubo acci	plotod agree	f dooth //	22a) (T		D014192	2	Nov	ember 2	26, 2010	I
12	-3		Vija yan	-		237 B I	,		,	enbelt,	Maryla:	nd 20	0770		
	Stat Registra	- I	DEC 0 1 2	Day, Year)	know		strar's Signatu								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2010 29472 State of Maryland / Department of Health and Mental Hygiene

		Registrar		Certificate	of Death		F	Reg. No.				
Physici		Month Day Year										
ledical Exam	iner	Mark D. McFarl	ane				Novembe	er 21, 2010	2127 hrs			
		4a. Facility Name (if not institution, g	ve street and number)		4b. City, Town,	or Location of Dea		4c. County o	f Death			
. 1		7741 Riverdale Road			New Carro	ollton		Prince G	eorge's			
Funeral		5. Social Security Number 6. 5	Sex 7. Age (In	yrs. last birthday)	If Under 1 Ye	ear If Under 24	Irs. 8. Date of Bi	rth(MM/DD/YYYY)	9. Birthplace (State or			
Director		594-17-2019	¥ _{M 2} F 42	2		ays Hours M	^{din.} 11/30)/1967	Foreign Jamaica			
					Yrs.				Country) =			
any		Usual Residence of Decedent 10a. State 10b. County	1100	. City, Town or Lo	cation				10d. Inside City Limits			
		, , , , , , , , , , , , , , , , , , , ,	e Georges	Glenn Da					1 X Yes 2 No			
te Maryland or 28a-f show Ged at once.	0		Georges	GIEIII D	ше				I Z Tes Z No			
Mary 28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha				
the?	ä	11201 Petworth I	_ane		2076	9		U.S.A.				
with ns 23	<u>ra</u>	11. Mantal Status	12. Was Decedent Eve	r in U.S. 13. 1	Was Decedent of H	lispanic Origin? (Specify Yes or No	0- 14. Race	- American Indian, Black,			
eath item	Funeral	1 Never Married 2 Marrie	d Armed Forces?		f Yes, specify Cub	an, Mexican, Pue	rto Rican, etc.)	White	, etc.			
her of		3 Widowed 4 Divorce	d If Yes, Give Year	1	Yes 2 X N	lo specify:		Specify:				
urs a tura	d b	15. Decedent's Education (Specify of	or Dates: Only highest grade complet	ed) 16a. Deced	dent's Usual Occup		of work done	16b. Kind of Bus	Lack iness/Industry			
2 ho	že	Elementary/Secondary (0-12)	College (1-4 or 5+)	during	most of working li	fe. DO NOT use r	etired)		•			
5-0036 led within 72 hours Hygiene. other than "natur	mpleted	12			Chef			Paradis	se Cove Rest.			
d wit	Соп	17. Father's Name (First, Middle, Las	t)			18.Mother's Na	me (First, Middle.	Maiden Sumame)				
115 al Hy ed o	Bec	Grandvill McFar	ĺane				n Richard	,				
21215-0036 uld be filed within 7 Mental Hygiene, marked other than	To B	19a. Informant's Name/Relationship (Type Print \	19h Mai	ling Address (Str			mber, City or Town	State Zin Code)			
nore, MD 21215-0036 ges I and 2 should be filed within 72 hours after death with the Maryland at of Heath and Montal Hygiene. If I filen 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once	F	Andrea McFarlane	• • • • • • • • • • • • • • • • • • • •		01 Petwoj							
md 2 salth raum		20a. Method of Disposition	(NIIC)		osition (Name of c		Date	Dale, MD	20769 City or Town, State			
S 1 a left to the trick		1 X Burial 2 Cremation 3	Removal from State	crematory or		errietery,	Date	20C. Eocalion -	City of Town, State			
Page nent cant: or otl		4 Donation 5 Other Specif	_	Gate of	Heaven (Cem. 1	2/4/2010	Silver	Spring, MD			
Baltimore, MD 21215-003 Departit. Pages I and 2 should be filed withit Department of Health and Mental Hygiene. In procram: If tiem 27 is marked other tu injury or other traumatic event, the Med		21. Signatur Funeral Service Lice		. 22	2. Name and Addre		endon /Ha	le Funera	al Homo			
E E E E		Pullen	ROUDE	9	013 Annar	olis Rd	. Lanham	, MD 2070	16			
Physician		23a. Part I. Enter the disease, or com		death. Do not ente	r the mode of dyin	g, such as cardiad	or respiratory and	est, shock, or hea	rt Approximate Interval			
/Medical	4	failure. List only one cause on e	each line. LGunshot Wound of	Hood					Between Onset and Death			
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseque									
		Commentative list annulations b										
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	nce of):								
	盲	cause. Enter Underlying Cause (Disease or Injury that initiated	a									
sit sd	Examiner	events resulting in death) Last	Due to (or as a conseque	nce of):								
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit												
760, cate be ex physician the burial	n/Medical	UNPENDED	AMENDED									
8760, tificate be ng physic as the bur	ž	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of					23d. Date of d				
68 Sertif		past 12 months?	1 Live birth 4 Pregnant at time		Fetal death 3	Ectopic preg	nancy	Month	Day Year			
Box 687 e death certification at the attending of the death of the dea	Sic	1 Yes 2 No 9 Unknow		or death 5	Other (Specify)							
O. B. trthe de by the	Physicia	Part II. Cther significant conditions		not regultion in th	o underluine ocupe	sives in Ded I	230 Did to	nhagas una contric	oute to the cause of death?			
P.O ires that to signed by be detac	ğ	Tart II. Other significant conditions	contributing to death but	not resulting in th	e underlying cause	given in Part I.			Probably 4 Unknown			
S, C							-					
y red	ompleted						24a. Was autor		ere autopsy findings available for to completion of cause of			
Recc The lar	Ĕ						perfo 1 ✓ Yes		eath? ✔ Yes 2 No			
tal Rection: The certificate ector, page	O	25. Was case referred to medical			26 Pla	ce of Death (Chec		2 110 1	V 163 2 140			
sicial Sicial	a	examiner?	Hospital: 1 Inpatient	2 ER/Outpatie		1Othor:		Residence 6	Other: Seens			
of Vital Records, g Physician: The law require. the this certificate has been sineral director, page 2 should be	ဥ	1 ✓ Yes 2 No 27. Manner of Death		28b. Time o		jury at Work?		how injury occurre	·			
~ .≅ . ≺ .≅ !	6	1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year) FOUND:	FOUND:	·	Yes 2 No	Subject sho					
SiOI Attend death death sctor:	gti	2 Accident Investiga		2046 hrs	555 F							
Division tal or Attendin rs after death. al Director: A	#	3 Suicide 6 Could no determine			reet, factory, office	building, etc.	28f. Location (Street and Number State) Ie Road, New C	r or Rural Route Number, City			
Di spital nours a neral I	Certification:	4 Momicide	(Specify) Local S	Street			7741 Riverda	le Road, New C	arrollton, MD			
Division of Vital Points on the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Physic	cian: To the best of my known	owledge, death oc	curred at the time,	date and place, a	nd due to the caus	se(s) and manner a	as stated.			
神神中	έ		er: On the basis of examina and manner stated.	uon and/or investi			at the time, date					
	0	001 0: 1			29c. Licer	nse number		29d. Date signe	d (Month, Day, Year)			
F. 2 F. 8	Me	29b. Signature and title of certifier										
F 2 5 8	Me	29b. Signature and title of certifier			0.0	.M.E.		November 2	22, 2010			
	Me	29b. Signature and title of certifier 30. Name and address of person who	completed cause of death	(Item 23a)	0.0	.M.E.		November 2	22, 2010			
5	Me	30. Name and address of person who	completed cause of death		O.C. Street, Baltin		01	November 2	22, 2010			
5		30. Name and address of person who		r 111 Penn			01	November 2	22, 2010			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene 1 - State of Maryland / Department of Health and Mental Hygiene 1 - State of Maryland / Department of Health and Mental Hygiene 1 - State of Maryland / Department of Health and Mental Hygiene 1 - State of Maryland / Department of Health and Mental Hygiene 1 - State of Maryland / Department of Health and Mental Hygiene 1 - State of Maryland / Department of Health and Mental Hygiene 2 - State of Maryland / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Departmen 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOV. 2010 **McCABE** JR. 1:20 **EMORY** Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WORCESTER BERLIN ATLANTIC GENERAL HOSPITAL Social Security Number 6. Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign OCT. 23, Year) 923 Months Days Hours Min. Yrs MARYLAND Director 221-20-9048 87 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No **SELBYVILLE** DELAWARE SUSSEX 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 19975 USA 38530 BLUEBERRY FARM ROAD 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō by 1 Never Married 2 X Married 1 ☐ Yes 2X No Specify: 3 Divorced Specify: WHITE "natural" Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) FARMER AGRICULTURE Be Department of Health and Mental Hy Important: If item 27 is marked oth, any injury or other traumatic event. other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ HUDSON SR. MARY **EMORY** Mc CABE Maryl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HELEN L. McCABE/WIFE 38530 BLUEBERRY FARM RD, SELBYVILLE, DE. 19975 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State REDMEN'S CEMETERY 11/29/10 SELBYVILLE, DELAWARE 4 Dopation 5 Other (Specify) 21. Signature Fureral Service Licens 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part 1. Enter the disease, or complications that cadsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Sepsis Onset and Death Physician disease or condition resulting in death) Days Medical Due to (or as a conse tilence of) Examiner Dirricle colitis Clustridium Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXA Due to (or as a consequence of) been signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Hip Fracture Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To Be Completed longestive Heart Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Physician: The 2 No Yes 2 No Vital 25. Was case referred to medica 26. Place of Death (Check only one) examiner?
1 X Yes 2 100 Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ō 27. Manner of Death 28a. Date of injury (Month. Day, Year) 28b. Time of injury **A** Certificate: al or Attending P s after death. Il Director: After t 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 11/01/2010 2 X Accident Unknown ^M 1 Yes 2 X No Subject fell. Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Road, Selbyville, Delaware 4 Homicide determined Home 24 hours a Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 29b. Signature and title of certifier Mill 11/25/10 MD066678-L 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9733 Healkway Drive, Belln MD 21811 1010 Giller 1010, M.D. 32 Registrar's Signatur State Registrar

2

4

SOW

1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25tate of Maryland / Department of Health and Mental Hygiene [] | Certificate of Death Reg. No. Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2:36 A M NOVEMBER DAVID CARL NASH 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Sex 1X M 2 ☐ F Funeral JUNE 10, Year) Months Days Hours MARYLAND Director 217-50-3673 63 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a, State 10c, City, Town or Location at Director Examiner must be notified 1 🗆 Yes 💥 No GRASONVILLE MARYLAND QUEEN ANNE'S 10f. Zip Code ь 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 21638 700 LONG POINT ROAD UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) College (1-4 or 5+) **2** Elementary/Seconday (0-12) traumatic event, the **EDUCATION** TEACHER and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JOSEPH BURKOWSKI IRENE CLEATOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 700 LONG POINT ROAD, GRASONVILLE, MARYLAND 21638 NANCY SUE NASH/WIFE 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot CHESAPEAKE CREMATION CENTER NOVEMBER 2010 1 Burial 2 XCremation 3 Removal from State STEVENSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 23 Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL 105 SHAMROCK ROAD, CHESTER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause og each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Seque itfally list ou citions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER and -transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death detached the Unknown 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Xes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy ructure Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical of Vital Hospital or Attending Physician: director, 26. Place of Death (Check only one) Be examiner? Hospital Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 🗶 No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After a completed filled in by the funeral iniury ural Accident 5 Pending Subject slipped and fell Division 2:00 a M 11/22/2010 Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home 28f. Location (Street and Number or Rural Route Number, City or Town, State) 700 Long Point Rd. 4 Homicide determined Grasonville,MD Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2 29c. License number 10 11/29/10 MP MS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapolis Melaine -cyert EVSOIT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death LEVEN DE Y Physician/ 154 MARGARET GUERNEY SEWARD NASH Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ler 1 Year If Under 24 Hrs. Days Hours Min. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months (Month, Day, Year) FEB. 10, 1932 Director 78 221-22-7941 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No MARYLAND QUEEN ANNE'S QUEENSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 NASH DRIVE 21658 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give land 21215-0036 1 Yes 2X No Specify. 3 Divorced 4 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **HEALTH CARE** REGISTERED NURSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ JAMES R. SEWARD MARGARET JUMP 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20524 TANAGER PLACE, LEESBURG, VIRGINIA, 20175 CYNTHIA HUDDLESTON/DAUGHTER Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State WOODLAWN of HEMORIAL (c) NOV. Date 7. 1 X Burial 2 Cremation 3 Removal from State PARK 2010 4 ☐ Donation 5 ☐ Other (Specify) EASTON, MARYLAND 21. Signature of Funeral Service Licenses FEULOWS HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND, at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause on each line Interval Between SEPSIS Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) hours Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cauce. Enter Underging Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Day Year ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Yes Other: ျှ in 24 hours atter uccur. he Funeral Director: After this or proleted filled in by the funeral di 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0059487 olul notser 11-23-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN BOTSIS, M.D. 219 S. WASHINGTON STREET, EASTON, MARYLAND, 21601

State Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November Betty Croom Norman 2010 10:45 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9707 Old Georgetown Road, #2419 Bethesda Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 8. Date of Birth Aug 8 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 X F Year) 9<u>21</u> Alabama Director 577-24-8115 89 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is an arked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Bethesda 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9707 Old Georgetown Road, #2419 20814 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married <u>۾</u> 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert F. Croom Alice Dunn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert K. Holder/Power of Att. 7101 Masters Drive, Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Goshen Church Cem. 12/01/2010 Laytonsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home Mª Millian MO1202 10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): Examiner Stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day Year 5 Other (specify) signed by the a d be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Atrial Fibrillation 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Diabetes Mellitus 24a Was an page performed? Yes 2 X No Alzheimer's Disease 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 K No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 1 X Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 5 Pending injury Accident Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D55258 November 29, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Gary Wilks, MD,

NGV 3 0 2010

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

7758 Wisconsin Avenue, #211, Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Ralph A. Nacrelli November 2010 8:30 a^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1000 Schumaker Woods Road Salisbury Wicomico Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 X M 2 🗆 72 Months Hours Min (Month, Day, Year) 07/16/1938 211-28-0545 Director Pennsylvania Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Me Ital Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Schumaker Woods Road 21804 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. \$ 1 Never Married 2 K Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Sales representative jewelry 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ralph A. Nacrelli Sr. Anna Galczynski 19a. Informant's Name/Relationship (Type, Print)
Kathleen Nacrelli/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Schumaker Woods Rd., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State injury or c 1 X Burial 2 Cremation 3 Removal from State Wiccini co Memoriale 11/29/2010 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD Park 21. Signature of Funeral Service Licensee HOTTOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Box 68760 E FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy signed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 1 Yes 2 g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The ☐ Yes 25. Was case referred to medical Division of Vital completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accider injury work? 5 Pending after death. 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 026278 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OCEAN CIXY Rd, SALISBURY, MD 21804 COWALL 2604

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2010 Dec. RUTH MARIE MAUMANN PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4040 Old Federal Hill Road Jarrettsville Harford Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗶 F Months Days Hours Min Country) Maryland 214-74-9480 98 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits MD. Harford 1 🗌 Yes 2 💢 No Jarrettsville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 4040 Old Federal Hill Road 21084 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces 1 ☐ Yes 2 XNo If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Johann Louis Wurzbacher Margaret Christina permit, Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 Ruth A. Phoebus (Daughter) 4040 Old Federal Hill Rd. Jarrettsville,MD. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec Date 10, cemetery, crematory or other place. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) John's Cem. 2010 Jacksonville, MD. 21. Signatura of Funeral Service Licens 22. Name and Address of Facility E.G. Kurtz & Son Funeral Herry <u>Home</u> Jarrettsville. 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final on gest in haant Physicians disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to fine ellations Display for the representation of cause. Enter Underlying Cause (Disease or iinjury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown jo Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy this certificate had director, page performe 2 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? 2 X No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 5 Pending injury 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number Medical 29a Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 Schilling Road Hunt Valley, Maryland 21030 Mark Lamos,

Registrar
DHMH 17 Rev 7/2009

State

			For State	State of	Marylan		artment of H		, ,	26		391.7	9
			Registrar 1. Decedent's Name (First, Middle, La	act)		Cei	lilicale UI L		2. Date of Dea	eg. No. U	1 13	3. Time of Dea	ath
	Physicia	an			DORFF				Month	Day	Year	7:56	
	/Medic		4a. Facility Name (If not institution, gir				4b. City, Town, or	Location of Deat	12	4c Cou	2010 nty of Death	7.50 2	
95	Examin	er			iber)				1	40.000		n art = n	
			17949 College Ro		7. Age (In yrs.	last hirthday)	If Under 1 Year	erstown If Under 24 Hrs.	8. Date of Birth	1		ngton olace (State or Fo	reian
	Funeral Director		201–16–3397	1 M 2 KF		Vrc	Months Days	Hours Min.	(Month, Day	, Year)	Cou	ntry)	i oigii
At-			Usual Residence of Decedent	/ '	86)			Aug. 25,	1924	V	rginia_	
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Li	imits
	Man -fsh fied	to	Maryland Washi	naton			Hagersto	ารสา				1 □ Yes 2 0	No
	r 28a	Director	10e. Street and Number	igcon			10f. Zip Code	7411	1	0g. Citizen	of What Cou	ntry?	
	3a o		17949 College Ro	oad			21	740			USA		
	ms 2	Funeral	11. Marital Status	12. Was Dece		S. 13. 1	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S	pecify Yes or No-		Race - Ameri	can Indian,	
0	after or Ite	ᆵ	1 ☐ Never Married 2 ☐ Married	Armed For 1 ☐ Yes If Yes, Give	2 🔀 No			Specify:	io nicali, etc.)		Black, White,	etc.	
3	ral", c	þ	3 X Widowed 4 ☐ Divorced	Year or Da	tes:		1 □ Yes 2 🙀 No	эреспу.		Spe	ecify:	White	
2-0030	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dieal Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)		(Give	dent's Usual Occupa kind of work done of	luring most of wo.	rkina	16b. Kind of	f Business/Ir	dustry	
7	ithin ne. Med	du	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use retired)					
V	ygier ygier ner th	S	12	6			Teacher		(F) 1.16:14		Educa	tion	
	be fil tal H d oth	Be	17. Father's Name (First, Middle, Las					18. Mother's Nar	me (First, Middle, .	Maiden Suri	name)		
<u>X</u>	Men Men arke	은	Isaac Clarence		<u> </u>	T			ay Heish				
<u> </u>	2 sh i and is m raum		19a. Informant's Name/Relationship	, , ,			ng Address (Street a						
ב ט	is 1 and 2 of Health a item 27 is other trai		Hazel Bussard-Per	sonal Re			Netz Rd.				21713 on - City or T		
5	ges it of h If ite or of		20a. Method of Disposition 1 Burial 2 □ Cremation 3	Removal from S	state		sition (Name of matory or other plac	1					
ашто	t. Pa tmen tant: ijury		4 □Donation 5 □ Other (Spec	A	Asb		metery			Baker,	West	Virginia	<u>a</u>
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Furieral Serving Lin	ensee		1	borne Fur 5 S. Conc			illiam	anort	MD 2170	5
			23a, Partt. Enter the disease, or cor	71	wood the deat						spor C	Approximate	<u> </u>
			shock, or heart failure. List only	one cause on ea	ach line.	n. Do not em	er trie mode or dyin					Interval Betwee Onset and Dear	an Ith
ا د ا	Physician		Immediate Cause (Final disease or condition resulting in death)	а.	EROSC		IC HEA	RT 1) ISEASE	-			
S.	/Medical Examiner			Due to (or as a conseq	uence of):							
	熱	7	Sequentially list conditions,	b. — Due to (or as a conseq	uence of):							
	ted 1sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (or ao a ooriooq	401.00 0.,1							
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (d	or as a conseq	uence of):							
2/00	cate be executed oblysician and the burial-transit	dical E		8.1									
00	certificate iding phys	edic		a									
X Q Q	certi nding Ise a	/Mic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo						23d.	Date of deliv	ery	
ă	death de atten	ciaı	in the past 12 months?		irth 2 □ Feta ant at time of d		⊒Ectopic pregnancy ⊒ Other <i>(spe</i> c <i>ify)</i>	,			Month	Day Yea	ır
į		Physician/Me	9 Unknown	9□Unkno	wn								
T.	that the		Part II. Other significant conditions	contributing to de	ath but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use c	contribute to	the cause of deat	h?
ecords,	requires een sign nould be	d by							1 □ Y	es 2□ N	o 3□Pro	bably 4 🕅 nki	nown
င္ပ	law rec as bee 2 shou	Completed							24a. Was a	an 24	4b. Were aut	opsy findings ava empletion of cause	uilable
r	slcian: The law certificate has birector, page 2 s	ш							autop: perfor	med2	death?		e of
VITAI	ifficat or, pe	e Cc	25. Was case referred to medical					26 Place of De	1 Yes ath (Check only or	-1	1 🗆 Yes	2 LI NO	
>	Physician: this certific	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	npatient 2	ER/Outpatie	nt 3 DOA Othe	ar:	lome 5/1 Resid		Other (Spec	ifv)	
ō	g Phy er thi eral c		27. Manner of Death	28a. Date of	of Injury h, Day Year)	28b. Time o	f 28c. Injur		28d. Describe h				
0	ndin tth. r: Aft e fun	ertification:	1 Natural 5 □ Pending 2 □ Accident investigation	,	ii, Day Tear)	Injury		Yes 2 □ No					
VISION	Atte	ifica	3 ☐ Suicide 6 ☐ Could not determine	28e. Place	of injury - At he	ome, farm, st	reet, factory, office		28f. Location (S City or Tow	itreet and Nu	umber or Rui	al Route Number	r,
5	s afte	Cert	4 E Normoldo	Ballali	19, 010. (<i>Opcon</i>	,,			Ony or row	n, Olale)			
	To the Hospital or Attending Physician: Within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director,	edical ((Check only 2 Medical Ex				h occurred at the tir						
	the hin 24	Med	one)	and manr	ner stated.		29c. Licens	n number		20d Data si	anad (Manth	Day Vansl	
	No No	Σ	29b. Signature and the of certifier		1	1 1					gned (Month		
}			11000		/~/		200	01711		121	01/2	110	
11	1-11		30 Name and address of person who	completed cause		n 23a) (Type,	Print) MEDICA	L CAMPU	S RD	HAM	ERSTO.	WN	
T	1-10		31. Date filed (Month, Day, Year)		i My		STE IS	D		1	102	1742	
200	Sta Registi		DEC 03	2010	giatiai s Signa		6.00						
Dh	MH 17 Rev 1/2	-01	m 1 1 1 15	ESTU /	Sections.	13.	hours!						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		. 101	artment of Health and Me ertificate of Death	ental Hygier Reg. 7 2. Date of Death	3e010 39480		
Physic /Medi Exami	cal	Dora Lee Paxson 4a. Facility Name (If not institution, give street and number) Loyalton Assisted Living	4b. City, Town, or Location of Death Hagerstown	Dec. 1,	2010 4c. County of Death		
Funeral Director		5. Social Security Number 228-28-6721 6. Sex 1 M 2 MF 7. Age (In yrs. last birthday 1 M 2 MF 84 Yrs.	If Under 1 Year II Under 24 Hrs. Months Days Hours Min.	B. Date of Birth (Month, Day, Yea 5 – 18 – 19	·		
Maryland a-f show	ctor	Usual Residence of Decedent 10a. State MD 10b. County Washington Hagers		-	Virginia 10d. Inside City Limits 1 Types 2 No		
h with the 23a or 28	Funeral Director	10e. Street and Number 20009 Rosebank Way	10f. Zip Code 21742	2. Date of Death Month Day Year Dec. 1, 2010 14:25p _M 15 16 16 16 16 16 16 16			
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Madical Examiner must be neithed at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ② □ No II Yes ② □ No II Yes ③ □ Otto II Yes ☐ No II Yes ☐ N	Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto F	ify Yes or No- ican, etc.)	Black, White, etc.		
d 2 should be filed within 72 hours alt ith and Mental Hygiens 127 is marked other than "natural", or traumatic event, the Medical Exami	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired) secretary	9	transmission		
2 should be filed and Mental Hygis Is marked other aumatic event,	To Be C	17. Father's Name (First, Middle, Last) Raymond Rex Myers					
		Jackie Blair daughter 138	45 McIntosh Circ	Route Number, Cit cle Clea	y or Town, State, Zip Code) r Spring, MD 2172		
t. Pa rtmen rtant:		+ Bonanon o Bonner (Spoon)	Lawii Celli.	2010 H			
permi Depa Impo			22. Name and Address of Facility Donald Edwin Tho P O BOX 310 Clea	ompson F	uneral Home, Inc		
Beath certificate be executed the scale of t	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	carelnoma eft pelvic ma avelnoma	85			
0 0	Physician/Medi		□Ectopic pregnancy □ Other (specify)				
w requires that the s been signed by th s should be detache	b	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.				
The law ate has b page 2 si	Completed	Athma		autopsy performed	? prior to completion of cause of death?		
S w	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Othor		6 ☐ Other (Specify)		
ding h. After fune		27. Manner of Death 1 Death Sequence 28a. Date of Injury (Month, Day Year) 28b. Time Injury 28b. Time	of 28c. Injury at Work? M 1 Yes 2 No	3d. Describe how in	njury occurred		
- 0	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 2	BI. Location (Street City or Town, St			
To the Hospital o within 24 hours at To the Funeral Di completely filled in	edical	29a. Certifier (Check outy one) 1	ath occurred at the time, date and place, a nvestigation, in my opinion, death occurre	nd due to the cause d at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)		
To the within 2 To the complet	M	29b. Signafure and title of certifier	29c. License number D 00 41131	29d. 1	Date signed (Month, Day, Year) Dec. 2, 2010		
H-3		30. Name address a person who completed cause or leath (Item 23a) (Type CO PRECES; M - D -	1124 OPAL CT	HAGA	Dec. 2, 2010 EPSTOWN, MD 217		
St	ate	31. Date filed (Month, Day, Year) 32. Aggistrar's Signature	1-41				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Anthony S. Payne November Medical 2010 10:00A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Cheverl Georges Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 1 ₺ M 2 □ F Months Days Hours Min Director 579-74-6568 Yrs Wash Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Ves 2 No DC Washington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4651 Nannie Helen Burroughs Ave , NE 20019 United States 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1975 1 ☐ Yes 2 No Specify. 3 Divorced 4 Divorced Specify Completed Black 1980 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Master Gardener Dept of Parks Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ပင Howard Jackson Edith Payne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important. If item 27 is any injury or other trainonce. 4651 Nannie Helen Burroughs Ave., NE Carolyn Payne/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20019 -DC 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 12/13710 4 Donation 5 Other (Specify) Quantico Nat. Cemetery Triangle, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine or Attending Physician: The law requires that the death certificate be executed and burial-trar resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year 2 🗌 No Unknown 9 Unknown signed by t significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page performe 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မှ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death injury 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined To the Hospital or within 24 hours af To the Funeral D Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State Registrar person who completed cause of death (Item 23a) (Type, Print) CATEVENIS

32. Registrar's Signature

AHES

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland	-			d Menta	Hygiene		00102
			Registrar		Cer	tificate of L	Death		Reg. No	2010	39482
Phy	sicia	n/	Decedent's Name (First, Middle, Last)					Mon	of Death	av Year	3. Time of Death
	/ledic		Linda Catherine Raz					Nove	mber 1	8, 2010	11:15P™
Ex	amin	er	4a. Facility Name (if not institution, give stre			4b. City, Town, or		eath		. County of Deat	
-			Anne Arundel Medica 5. Social Security Number 6. Sex			Annapoli		u. L.		nne Arur	
Fun Dire	eral		I - I - I - I - I - I - I - I - I - I -	7. Age (In yrs. la	60 Yrs.	If Under 1 Year Months Days		/lin. (Mon	of Birth th, Day, Year)	9. Birt	hplace (State or Foreign untry) nington, D.C.
1/2			218-54-8653 Usual Residence of Decedent		00 110.			Marc	h 1, 1	950 Wash	iington, D.C.
and sho v	l at	ō	10a. State 10b. County	10c. City	, Town or Loc	ation					10d. Inside City Limits
Mary 28a-f	otifie	rec	Maryland Anne Arun	del	Edgewa	ter					1 ☐ Yes 2 🕱 No
a or	pe uc	D	10e. Street and Number			10f. Zip Code			10g. Ci	tizen of What Co	untry?
n with	unst	Funeral Director	3906A River Club D	rive_		2	1037			USA	
deatl	ner n			. Was Decedent Ever in U.S Armed Forces?	. 13. V	as Decedent of Hi Yes, specify Cuba	ispanic Origin? n. Mexican, Pu	(Specify Yes o	or No-	14. Race - Amer	
36 after I", or	kami	1 by	1 Never Married 2 X Married	1 ☐ Yes 2 🔀 No If Yes, Give		☐ Yes 2 No		,	,	Black, White Specify: Wh	nite
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho	SalE	Completed by	3 Widowed 4 Divorced 15. Decedent's Education	Year or Dates.					-		
72 h	Medi	du	(Specify only highest grade	completed)	(Give k	ent's Usual Occupa ind of work done d NOT use retired)	ation during most of i	working	16b. K	(ind of Business I	ndustry
vithin jiene.	a		Elementary/Seconday (0-12)	College (1-4 or 5+)		Manager			Co	nstructi	on
d Hyg	/ent,	Be	17. Father's Name (First, Middle, Last)				18. Mother's i	Name (First, M			
Maryland 12 should be filed v 14 and Mental Hyg 27 is marked othe	tic e	유	Henry Arthur Segers	trom			Rose Sa	ara Bon	anno	,	
fary should and N is ma	E		19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	Address (Street a	and Number or	Rural Route N	lumber, City or	Town, State, Zip	Code)
M 2 S adith a	er tra		Ronald Razzano / Hus	sband	3906A	River C1	ub Driv	e, Edg	ewater	, Maryla	ind 21037
ore, Maryland 21215-0036 et and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show	[호		20a. Method of Disposition	20b. Pla	ace of Dispos	ition (Name of atory or other place	!	Date		ocation - City or	
Page nent o	ury or		1 🔀 Burial 2 □ Cremation 3 □ Rei 4 □ Donation 5 □ Other (Specify)	Laker	nont Merr	orial Garde		-23-20	lO Davi	dsonvil	le, Maryland
Baltimore, oermit. Page 1 and Department of Hea	any injury ol once.		21. Signature Sylveral Service Licensee		22.	Name and Addres	s of Facility (George	P. Kal	as Funer	ral Home
	je 9	3. 5	Monde		29	73 Solom	ons Isl	land Rd	., Edg	ewater,	MD 21037
			23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one c	ations that caused the death. cause on each line.	Do not enter	the mode of dying	g, such as card	liac or respirat	ory arrest,		Approximate Interval Between
Physic		8	Immediate Cause (Final disease or condition	Castric	Cani	15 M	1-tustat	10-			Onset and Death
Med Exami	_		resulting in death)	Due to (or as a conseque	ence of):						
		-	Sequentially list conditions, b.	5							
p :	lisit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a conseque	ence ot):						
(ecut	II-tra	Exa	that initiated events c resulting in death) Last	Due to (or as a conseque	ence of):						
Box 68760 death certificate be executed te attending physician and	una	dical									
760 ficate b g physic	s the	led.	_ u.,								
certific	ase and	١	IF FEMALE: 23b. Was decedent prefinant 23c.	. If yes, outcome of pregnan						23d. Date of deli	verv
Box death c	0 0	icia 	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 Fetal 4 Pregnant at time of de		Ectopic pregnancy Other (specify)	у		_	Month	Day Year
ords, P.O. Box 687 v requires that the death certifics the sear signed by the attending personal to death of the second for th	acije	by Physician/Me	9 Unknown	9 Unknown							
P.O.	20 2	by I	Part II. Other significant conditions contril	buting to death but not resul	ting in the un	derlying cause give	en in Part I.	23e.	Did tobacco u	ise contribute to	the cause of death?
'dS, quire en si	one I	ted						-	1 Yes 2	No 3 □ Pro	obably 4 🗌 Unknown
aw re	N SI	Completed						24a.	Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
The late h	haife haife	8						1 🗆	performed? Yes 2 No	death?	2 🗌 No
tal cian; ertific	i cic		25. Was case referred to medical examiner?	-11-11			ce of Death (C				
hysia his o		유	1 ☐ Yes 2 ☑ No	1 Nnpatient 2 E		3 DOA Other	r: 4 🗌 Nursing	g Home 5 🗆	Residence 6	Other (Specif	5/)
ling F		Certificate;	1 Natural 5 Pending	28a. Date of injury (Month, Day, Year)	8b. Time of injury	28c. Injury work?	?	28d. Desc	ribe how injury	occurred	
SIO! ttend death death		<u>≌</u>	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	20 51 411			Yes 2 No				
DIVISION Of VITAL RECORDS, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the Commission of Figure 1 in the funeral princes of the prince of the death of the death of the princes of the prince of the princes of the	<u> </u>		4 ☐ Homicide determined	 Place of Injury - At hom building, etc. (Specify) 	ie, tarm, stree	et, ractory, office			ion (Street and or Town, State)	d Number or Rura	al Route Number,
spital		edical	29a. Certifier 1 Certifying Physicia	n: To the best of my knowled	dge death of	cured at the time	date and place	and due to t	ne callea(e) an	d manner as stat	od
e Ho 24 h e Fur		Med	(Check 2 - Medical Examiner:	On the basis of examination a ractioner: To the best of my l	and/or investi	ation, in my opinior	n, death occurre	ed at the time	date and place	and due to the co	nuce(s) and manner stated
To the			29b. Signature and title of certifier			29c. License		praco; ara dac		e signed (Month,	
			MANMO	Mark Sanch	.02	0640	89		11/10	12010	
	113	ŀ	30. Name and address of person who comp			nt)					
	100		Mark Sandrez	MO JOOL M	edica	1 Parky	us 1	hagael	, M	D 214	0
	State		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	re 6		,				,
Reg	istra		NOV 2 3 201	U Keneur	B. 1	arks					

Box 68760 P.O. Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica of Vital completed filled in by the funeral director, Division s after death.

Baltimore, Maryland 21215-0036

Registrar

10

Medical

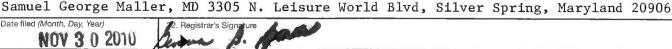
31. Date filed (Month, Day, Year) State NOV 3 () 2010

29a. Certifier

(Check

only one)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

11/22/2010

29c. License number

D0050612

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® State
Registrar Amend#20b. PerFHPCC12-7-10cr Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 24, November Mildred Ruth Rutledge 2010 1954 Ρ M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign
Country) Months Days 1 □ M 2 🛛 F Director 240-33-9873 1966 North Carolina March 21, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County or items 23a or 28a-f show inver must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo 1 XYes 2 No Maryland Prince George Largo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10117 Prince Place Funeral 20774 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: African American δ Specify EXS Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th <u>Administrative Assistant</u> Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any injury or other traumatic evone. Ray Oats 2 Ernestine Graham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Taylor - Ex-Husband 11263 Raging Brook Drive Bowie, Maryland 20720 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection 4 ☐ Donation 5 ☐ Other (Specify) 2010 Clinton, Maryland ature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, d NE Washington, DC 4001 Benning Road NE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** Multi Drug Resistant Pseudomonal Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypoxemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) certificate be executed burial-tran Ventricular Fibrillation and Due to (or as a consequence of): Box 68760 attending physician for use as the buris Physician/Medical Cytomegalovirus Infection IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year 5 Other (specify) P.0. 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 🔼 No 1 □ Yes 2 🗆 No 1 ☐ Yes Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director; in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the To the within ? To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sanguetha. R D69835 November 25, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sangeta Ranganath 1500 Forest Glen Road Silver Spring, Maryland 31. Date filed (Month, Day, Year) 32. Registra 's Sign State DEC 0 1 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Nov. *1334* m <u>J</u>oyce Rhodes Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HICOMICO If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Days Hours Min 04 26 1942 New York **Director** Yrs. 68 059-54-5865 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 917 Gateway Street 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. \$ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Disabled n|a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norris Taylor Charlotte Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Lewis friend 808 South Schumaker Drive, Apt. 1A, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 200. Place of Disposition (varies of cometery, crematory or other place)
Anatomy Gifts Registry 11 29 2010 Hanover, Maryland 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) .22. Name and Address of Facility Holloway Funeral Home.P.A. 501 Snow Hill Rd., Salisbury, Maryland 21804 21. Signature of Funeral Service Licer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events the burial-transit and Due to (or as a consequence of): resulting in death) Last the attending physician the for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No page 2 should be detached Unknown g 🗌 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No death? 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital ၉ 2 🗌 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title certifile 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

Snyder Do DME

CARROLL ST. SALISBURY M.C. 21801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Dale Eugene Reed, Sr. December 2010 12:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Golden Living Center Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 € M 2 🗆 F 217-28-7002 80 **Director** March 12,1930 Maryland Usual Residence of Decedent 10c. City, Town or Location / show 10b. County 10d. Inside City Limits ä or 28a-f sh 1 ☐ Yes 2 ☑ No Director Maryland Washington Cascade 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be - 23a c 25441 Cascade Road 21719 U.S.A.death \ Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Armed Forces?

1X Yes 2 \(\text{No}\) No 1949
1Year or Dates: 1956 filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Signal Guard RailRoad 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fil Department of Health and Mental H Important: If item 27 is marked oth any injuy or other traumatic even once. Be Pages 1 and 2 should be nent of Health and Mental Jessie Reed Margaret Gladhill ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Kayhoe (Daughter) 211 West Fifth St. Waynesboro, Pennsylvania 17268 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State December 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg, Maryland 4 Donation 5 Dother (Specify) Smithsburg Crematory 8, 2010 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 ee 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 5 years disease or condition resulting in death) illin Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the cause of the cause o Due to (or as a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of) Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed? Yes 2 No certificate or Vital Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No after death | Director: / d in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

low

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

nuell Street Hagestonne MD 21740

Amend #17,18,1				-		_	e.
AA W. IBBIUI	L.	ept. 11/22/2010 lo State of Maryland / Department of Health a 1 - Registrar Certificate of Death	and Mei	ntal Hy	giene	2011	39488
		Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)	2	Date of Dea	Reg. No	- 0 1	7 0 3 4 0 0
Physician Medica		Louis Charles Senes,		Month	Da	2010 Yes	3. Time of Death
Examine		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of	of Death			. County of D	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I If Under:	24 Hrs n	Date of Birt			
Director		214-40-8149 1 M 2 - F 67 Yrs. Months Days Hours	Min.	Month, Day	y, Year)	943	Birthplace (State or Foreign Country) Marvland
how at	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			-		
//aryla 8a-f s tified	Ulrector	Maryland Anne Arundel Annapo	lis				10d. Inside City Limits 1 ☑XYes 2 ☐ No
h the Na or 2	2	10e. Street and Number 10f. Zip Code				izen of What	
Ind 21215-0036 filed within 72 hours after death with the Maryland tall Hygiene. 3d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at the Reformulated by Eringral Disperse	runerai	440 Dewey Drive 21401				U.S.A.	·
er dez	5	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 12. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican, If Yes, specify Cuban, If Yes,		Yes or No- in, etc.)		14. Race - Ar Black, Wi	nerican Indian, nite, etc.
21215-0036 within 72 hours after giene. ten "natural", o ter than "natural", o ten the Medical Exam.		3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates, 1962–66				Specify: V	White
21215-003 inthin 72 hours a light of the matural tream and the medical Extension of the medical extension of the medical	H Die	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most	of working		16b. Ki	nd of Busine	ss Industry
ld 212 led within Hygiene. other tha ent, the I		Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use retired) 12 Waiter			F	Restaur	ant
land 2		17. Father's Name (First, Middle, Last) Mar 10 Senesi	er's Name (Fir		Maiden S	Surname)	
Maryland 2 should be fled th and Mental Hy 27 is marked out traumatic event To Re	1	Louis Frank Senesi	Unkno	P.L.		th Anna	
		19a. Informant's Name/Relationship (Type, Print) Dominic Senesi/son 19b. Mailing Address (Street and Number 4.40 Dewey Drive 1	r or Rural Roo Anna po	ute Number lis, i	, City or Mary	Town, State, . Land	Zip Code) 21401
Baltimore, M semit. Page 1 and 2 s bepartment of Health mportant. If item 27 minjury or other tra	1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	T	20c. Lo	cation - City	or Town, State
timor t. Page 1 tment of tant; If it	1	4 ☑ Donation 5 ☐ Other (Specify) Anatomical Board of MD					
Baltimor permit. Page 1 a Department of h Important: if its any injury or of		21. Signature of Funeral Service Licensee 22. Name and Address of Facility			-		
	+	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as c				mapoli	Approximate
Physician/		Immediate Cause (Final					Interval Between Onset and Death
Medical Examiner		resulting in death) a. The Why ocardial in twelve as a consequence of:					
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):	e plus	Int Par		hourt	1 7 days
kecuted and al-transit	1	Cause (Disease or linjury	R		P Cc	new	
9 F 12 F	:	that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL CYMMINE of the consequence of the co		-			
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but Medical Certificate: To Be Completed by Physician/Medical		d. CERTHUM					
Division of Vital Records, P.O. Box 68760 at or Attending Physician: The law requires that the death certificate by a fier death. In Director. After this certificate has been signed by the attending physical in by the funeral director, page 2 should be detached for use as the back that the funeral control of the completed by Physician/Medic		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				3d. Date of d	elivany
BOX death he atte ed for		in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Live Birth 2 ☐ Fetal death 5 ☐ Other (specify)			~	Month	Day Year
P.O. Bc es that the designed by the abe detached for the stacked 1	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	- 1.	OOs Did tol			to the control of death 0	
lires the signer of the signer		Acute kidney Injury			_		to the cause of death? Probably 4 Unknown
cord w request been as been 2 should	Î	Peripheral Vascular Disease		24a. Was ar		24b. Were a	utopsy findings available
Records, P. The law requires the rate has been signed page 2 should be d.		Tobacco and alcohol above		autops perform 1 Ves	ned?	death?	o completion of cause of es 2 ☑ No
ital ician: certific ector,	2	25. Was case referred to medical 26. Place of Death	(Check only		110		2 2 110
un of Vital I dding Physician: Tith. After this certifice is funeral director, g	2	27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury ct	sing Home	_			cify)
on on on ding sath. or: After tune fune fireate		1 Natural 5 Pending (Month, Day, Year) injury work? 2 Accident Investigation Nov 01.2 200 M 1 Yes 2 1	P+	Describe ho	lacal	ed onto	wheelcheir
vision After de linecto n by the by the certification of the certificati		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. L	ocation (Str	eet and	Number or R	ural Route Number,
Djishtal ours a ours a ours a leral D filled i	1	29a. Certifier 1 PCertifying Physician: To the best of my knowledge death occurred at the time data and all		DALINI	nar.	MD	1 GHENL SWEET
Division of the Hospital or Attending P in 24 hours after death he Funeral Director. After tipleted filled in by the funera Medical Certificate:		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and plate only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occured in the time of the basis of examination and/or investigation, in my opinion, death occured in the time of the basis of my knowledge, death occured at the time, date and plate of the basis of examination and/or investigation, in my opinion, death occured at the time, date and plate of the basis of examination and/or investigation, in my opinion, death occured at the time, date and plate of the basis of examination and/or investigation, in my opinion, death occured at the time, date and plate of the basis of examination and/or investigation, in my opinion, death occured at the time, date and plate of the basis of examination and/or investigation, in my opinion, death occured at the time, date and plate of the basis of examination and/or investigation, in my opinion, death occured at the time, date and plate of the basis of examination and/or investigation, in my opinion, death occured at the time, date and plate of the basis of examination and/or investigation, in my opinion, death occured at the time, date and plate of the basis of examination and/or investigation, in my opinion, death occured at the time.	urrod at the tir	ma data and	d place	and deed to the	
To the Common Co		29b. Signature and title of certifier 29c. License number	- process with			signed (Mon	
	-	MD D71167			11-	08-2	2010
W	3	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tracy Timmons MD 22 S. Greene St	2.4		, -		
State	3		Balton	ione	m	21	201
Registrar		NOV 2 2 2010 Seven S. Spares					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 19,2010° 1:30p M Patrick R. Sullivan Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6117 Owings Beach Road Anne Arundel Deale Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 ₹ M 2 □ F Months Days Hours 0276771940 70 Baltimore, MD 220-36-0578 Yrs Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MDAnne Arundel Deale 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6117 Owings Beach Rd. 20751 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 ★★es 2 □ No 1958— Black, White, etc 1 Never Married 2 Married ঠ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 🛣 No Specify White 3 Widowed 4 Divorced Completed Specify: 1960 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 thand Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 Police Officer Annapolis City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ other traumatic Patrick T. Sullivan Beulah Jester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau <u>Katie Gaver</u> Daughter General Hwy Millersville. MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 KX remation 3 Removal from State 11/23/2010 4 Donation 5 Other (Specify) Atlantic Crematory Glen Burnie, MD Signature of Funeral Septce licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 7 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final hysician/ disease or condition resulting in death) 10 Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Day the 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 perform certificate 1 2 🗆 No Yes 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2V No Other: 1 Tes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of e Hospital or Attending Pin 24 hours after death.

Funeral Director: After the funeral filled in by the funeral Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 2 No М 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) nin 24 hours a the Funeral D pleted filled i Medical Certifying Plysician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Exam her: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nur To the within 2 e Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29c. License number D57028 NOV.

Registrar DHMH 17 Rev 7/2009

Box 68760

Records, P.O.

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD GOC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 004-38-5452 1 M 2 D F 68 Country) 4/12/1942 Yrs Director Maine Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director must be notified MD Anne Arundel Millersville 1 Yes XX No ö 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 1105 Cecil Ave. South 21108 USA ral", or items? 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify. White Specify: "natural" 3 Widowed 4 Divorced Year or Dates. Vietnam Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur iury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Management NSA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ William James Stevens Mona Jenny Colbath 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1105 Cecil Ave. Millersville, MD 21108 Vincenza Stevens 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Atlantic Crematory 11/23/2010 4 Donation 5 Other (Specify) Glen Burnie, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral al Annapolis, MD 21401 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) len Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ⊆ g ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has performed 2 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes ည Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred To the Funeral Director: After completed filled in by the funer 1-Naturai (Month, Day, Year) injury 5 Pending Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours or To the Funeral I Medical 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of Gertifie

State Registrar Name and address of person who complete

2

dause of death (Item 23a) (Type, Print)-

1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death hysician/ 2010 November 7:45 A M Helen V. Spears Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 3063 Shad Place Riva . Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🔽 Months Days Hours nth, Day 1916 Maryland **Director** 219-28-1111 94 Jän Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 213 Rosewood St. 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ð Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Specify: Completed Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Crownsville (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th State Hospital 0 Psychiatric Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard L. Brice Florence H. Chase 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce A. Simms(Daughter) 3063 Shad Place Riva, Md. 21140 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brewer Hill 11-23-10 Annapolis, Md. Mane Research Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee B. Reese 821 West St. Annapolis, Md. 21401 M0048 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Inple Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sexuantially fist our fittings Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy for Pregnant at time of death 5 Other (specify) Month Day Year the s Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 1 Yes should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy perform death? ☐ Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? (2 Other: 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No upleted filled in by the Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe NOVEMBER 17, 2010 me wer 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Werne anne

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) NOV 2 3 2010

				State of Marylar				•	•	•
			For State Registrar	Otate Of Ivial year		tificate of E		, 0	g. No. 2 0 1 0	39492
	استست		Decedent's Name (First, Middle, Last)		-			2. Date of Death		3. Time of Death
سمسر	Physicia Medic		Joan Louise Snyde	r				December	Day Year 2010	1:53 A M
,	Examin	er	4a. Facility Name (if not institution, give stre	et and number)			Location of Death		4c. County of Dea	
	Funeral		18816 Dover Dr. 5. Social Security Number 6. Sex	7. Age (In yrs. I	last birthday)	Hagerst If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	on County thplace (State or Foreign
п	Director		200-24-1201	M 2 X F 78	Yrs.	Months Days	Hours Min.	larch 29	1932 Pen	nsylvania
	how how	٦	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Loc	eation				10d. Inside City Limits
	farylar Ba-f s tified	Director	Maryland Washingtor		gerstow					1 🎇 Yes 2 □ No
	a or 2	I Di	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral	18816 Dover Dr.			21742			U.S.A.	
'	or deal		11. Marital Status 1 ☐ Never Married 2 ☒ Married	 Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No. 			spanic Origin? (Speci n, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit	
036	rsafte iral", o	Completed by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	1	☐ Yes 2 X No	Specify:		Specify: W	hite
2-0	2 hou "natu edical	plet	15. Decedent's Educ (Specify only highest grade		(Give k		ation Juring most of working	, 1	6b. Kind of Business	Industry
121	within 7 giene. er than t, the M	Com	Elementary/Seconday (0-12)	College (1-4 or 5+)	Homen	NOT use retired)			Personal	Posidonas
d 2	filed w al Hygi d other event, t	Be	17. Father's Name (First, Middle, Last)	<u> </u>	Tollici	laker	18. Mother's Name (Residence
ylar	should be fil and Mental is marked aumatic ev	욘	Roy G. Hoffman				Edna H. I	Hoffman		
Mar	shou n and 7 is m raum		19a. Informant's Name/Relationship (Type,	*		-	and Number or Rural I			o Code)
e,	and 2 s Health tem 27 other tra		James M. Snyder-hus 20a. Method of Disposition			Dover D	r. Hagerst		0 21742 Oc. Location - City or	Town State
Baltimore, Maryland 21215-0036	permit. Page 1 Department of I Important: If it any injury or or		1 ☐ Burial 2 🕅 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemetery, crem	atory or other place	ory 12-2-2		•	, Maryland
alti	rmit. P partm portar y injur	7	21. Signature of Funeral Service Licensee	- Oili.			s of Facility Doug			
m	an III De	-	Dangles A.	Fine	13	331 Easte	rn Blvd. Ì	North Ha	gerstown,	
			23a. Part 1. Enter the disease, or complication shock, or Keart failure. List only one of	ouce on each line						Approximate Interval Between
F	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	UNDIFFEREN;	TIATRO	PANO	restre	carem	omp	3 moulty
	Examiner			Due to (or as a consequ	uence of):					
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):					
	cuted ind transit	xam	Cause (Disease or iinjury that initiated events c.							
_	e be executed ysician and e burial-transit	cal Examiner	resulting in death) Last	Due to (or as a consequ	uence of):					
			d .							
89	eath certificate t attending phys I for use as the I	M/ns	200. Was decedent pregnant	. If yes, outcome of pregna		Fatania aragnasa			23d. Date of de	livery
Box 6876	death he atte ed for	Completed by Physician/Med	in the past 12 months? 1 Yes 2 No	4 Pregnant at time of c		Ectopic pregnancy Other (specify)	у		Month	Day Year
P.O.	r requires that the de been signed by the should be detached	Phy	9 ☐ Unknown Part II. Other significant conditions contri		ulting in the ur	nderlying_cause give	en in Part I.	23e Did toba	cco use contribute to	the cause of death?
S, D	ires th signe d be c	d by	Hyperteurion,	atual p	Brile	ation				robably 4 Unknown
ord	v requ	olete	manota molli	tus				24a. Was an		topsy findings available
ဒ္ဓင	rsician: The law rs certificate has birector, page 2 s	omi	1) in the contractor					autopsy performe	ed? death?	completion of cause of
Tal.	stiffica ctor, p		25. Was case referred to cal examiner?				ace of Death (Check o		2 NOT 1 LES	2 - 140
Division of Vital Records,	Physic this caral dire	၉	1 Yes 2 No	1 Inpatient 2			4 Nursing Hom		ce 6 Other (Spec	ify)
n 0	ding the the funer funer	Certificate:	1 Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work? M 1 🔲		d. Describe how	injury occurred	
Sio	or Attending after death. Director: After In by the funer	ı titi	3 Suicide 6 Could not be	28e. Place of Injury - At ho				f. Location (Stree	et and Number or Rui	ral Route Number,
<u>≥</u>	tal or rs afte al Dire		TE TIOTHOLE GOLDHING	building, etc. (Specify)			City or Town, S	State)	
	Hospital 24 hours Funeral I	Medical		an: To the best of my knowl On the basis of examination						
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. the Funeral Director: After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the			ractioner: To the best of my			time, date and place,	and due to the ca		stated.
	- 3 - 6		SAMUEL COLA	n mo		1)366	655	Ď	ee, 1 2	.010
			30. Name and address of person who comp	pleted cause of death (Item	23a) Type, Pr	int) Co	mus 11 -	11.	/	21740
SH	1-4					VIIR LL	W. HAge	isteal	i MD 3	11140
	Stat Registra		31. Date filed (Month Per Year) 2	32. egistrar's Signat	ture	and I	•			

10-09150 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Stephen Stottlemyer State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Time of Death November 28, 2010 Medical Examiner 2340 hrs Stephen Stottlemver 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 1321 Lindsay Lane Hagerstown Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Country) Months Days Hours Director 1 X M 2 217-56-1490 55 23 1955 Wash. D.C. Usual Residence of Decedent 10d Inside City Limits 10a State 10b. Count 10c. City, Town or Location 1 X Yes 2 No or 28a-f show or items 23a or 28a-f show must be notified at once. Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Maryland Washington Hagerstown 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1321 Lindsay Lane 21742 Funeral 11 Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married Yes Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year Examiner Specify: White ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) item 27 is marked other than 'traumatic event, the Medical Salesman Retail 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Erman Stottlemver Gail LaVerne Burton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail L. Stottlemyer - Wife Lindsay Lane Hagerstown. Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Hagerstown CRematory 12/3/10 Hagerstown, Maryland 4 Donation 5 Other Specify Ħ 22. Name and Address of Facility 21. Signature of Funeral Service Lie Minnich Funeral Home Ε. Wilson Blvd. Hagerstown. Maryland 21740 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval Between Onset and failure. List only one cause on each line Medical Death a Acute Coronary Artery Thrombus Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b Hypertensive Atherosclerotic Cardiovascular Disease Sequentially list conditions, Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - transi sician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Phys detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed certificate has been s ector, page 2 should 1 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? director, page ✔ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural Pending 1 Yes 2 No filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) (Specify) Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. November 29, 2010

17-45

DHMH 17 Rev 1/2001

OCMF 2006

31. Date filed (Month, Day, Year) State Registrar

32. Refistrar's Signature

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

w 30. Name and address of person who completed cause of death (Item 23a)

OCME

Patricia Aronica-Pollak MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Swafford Medical Nov 2010 0800 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9112 Steam Valley Lane Clinton Prince George's **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months Days 1 □ M 2 □ yF Hours Min (Month, Day, Year, Director 234-84-7619 81 Sept 1020 Bessemer Alabama Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🔀 No Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 9112 Steam Valley Lane 20735 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent 2. Armed Forces?
1 ☐ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify. **Black** 3 ₩Widowed 4 □ Divorced Specify 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 75 Department of Heatth and Mental Hygiene. Important: If item 27 is marked other trainment any injury or other traumatic event, the Ma Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ephriam Handley Janney Payne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City, or Town, State, Zip Code) 8005 Old Parsonage Court, Alexandria, VA 22315 Lisa Swafford-Brooks -Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov 27,2010 Clinton, Maryland Resurrection Cemetery Signature of Funeral Service Licensee Lee Funeral Home, Inc. 22. Name and Address of Facility M01533 6633 Old Alexandria Ferry Rd, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a conse, United it To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🗶 No Pregnant at time of death Month signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>호</u> Completed 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy **Director:** After this certificate in by the funeral director, pag 1 Yes 2 No ☐ Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

232

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

31. Date filed (Month, Day, Year,

NOV

DHMH 17 Rev 7/2009

	Plea - For	ase Type or Pr State of M	<mark>int in Black</mark> 1aryland / De _l			-	_	gible.		
	State Registrar		Ce	ertificate of L	Death	F	Reg. No.	10	39491	
/sician/	Decedent's Name (First, Middle					2. Date of Dea Month		_ Year _	3. Time of Death	
ledical	4a. Facility Name (if not institution	mour A. Soko	atch_	45 City Tayon o	r Location of Death	Novembe		2010	9:04 0	
miner	13402 Silve 5. Social Security Number	r Moon Way		Sili	ver Sprin	ıg		Montg	omery	
ral tor	111-28-7131 Usual Residence of Decedent	1 M M 2 \square F	ge (In yrs. last birthday 74 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day June 25	1936	9. Birthi Coun	blace (State or Fore try) Marylan	
tor	10a. State 10b. County		10c. City, Town or I	ocation				1	0d. Inside City Lim	
ed by Funeral Director		gomery			ilver Spr				1 Yes 2 X	
ral	10e. Street and Number 13402 Silve	+ Maan Mau		10f. Zip Code	20904		10g. Citizen of			
-Ine	11. Marital Status	12. Was Decedent		. Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	14. Rac	u.s		
by	1 Never Married 2 X Mar	If You Give] No	If Yes, specify Cuba 1 ☐ Yes 2 🗶 No		o Rican, etc.)	Blac Specify	ck, White,		
eted	3 Widowed 4 Divorced	Year or Dates	eacetime	edent's Usual Occup					White	
Completed		est grade completed)	(Giv	e kind of work done (DO NOT use retired)		king	16b. Kind of B	usiness In	dustry	
ပိ	Elementary/Seconday (0-12)	College (1-4 or 4	Human	Resource	s/Vice P	resident	Holy	Cross	Hospita	
To Be	17. Father's Name (First, Middle, I	· ·			18. Mother's Nan	ne (First, Middle, f				
-		e Sokatch				Kline				
	19a. Informant's Name/Relations Ann Sokatch			iling Address (Street i 2 Silver I						
	20a. Method of Disposition	Spouse	20b. Place of Dis	oosition (Name of		Date	20c. Location			
3	1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 ☐ Removal from State		ematory or other plac em. Gardes		6/2010	Ola	ou M	aryland	
once. Complete	21. Signature of Funeral Service I		070 -	22. Name and Addres	ss of Facility H in	ON-Rinal	di Fund	enal	Homo In	
Medical Certificate: To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Due to (or as	a consequence of): a consequence of): a consequence of):							
Physician/Medic	FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 Unknown									
þ	23e. Did tobacco use contribute to									
Completed	1 Yes 2 X No 3 2								osy findings availal	
дшо						autops perfori	med?	prior to col death?	mpletion of cause	
	25. Was case referred to medical			26. Pl	ace of Death (Chec	1 Yes	2 X No	1 Yes	2 🗆 No	
To Be	examiner? 1 🗌 Yes 2 🗶 No	Hospital:	ient 2 🗆 ER/Outpati	Oth	ar'	ome 5 🗷 Reside	ence 6 Othe	er /Snecify		
Certificate: 7	27. Manner of Death 1 🕱 Natural 5 🗌 Pendir 2 🔲 AccidentInvestig	28a. Date of inju (Month, Da	ury 28b. Time	of 28c. Injury	/ at	28d. Describe ho				
	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		ury - At home, farm, s c. <i>(Specify)</i>	treet, factory, office		28f. Location (St City or Town		er or Rural	Route Number,	
Medical	(Check 2 Medical E only one) 3 Certifying	Physician: To the best of xaminer: On the basis of a Nurse Practioner: To the	examination and/or inve	estigation, in my opinion, death occurred at the	on, death occurred a e time, date and pla	it the time, date an	d place, and due	e to the cau	use(s) and manner s	
i	29b. Signature and title of certher		//	29c. License		2	9d. Date signed		,	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
	Barry Rosenbau				Kensinat	on. Maru	land 20	1985		
tate	31. Date filed (Month, Day, Year)		ar's Signature	A Paralle				_, _, _,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2010 John LeFevre Scott November 9:45 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wilson Healthcare Center Gaithersburg

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Montgomery Social Security Number 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1 M 2 □ F 203-10-1546 94 Director 16 1916 Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examination is be notified at
once. 28a-f show 1 ☐ Yes 2 ▼No Directo Maryland | Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 301 Russell Avenue 20877 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc affiled Folces: 1♥]Yes 2□No World IfYes, Give Year or Dates:War II 1 Never Married 2 Married 1 ☐Yes 2 ☑ No Specify: ģ Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ William A. Scott Grace LeFevre 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Thompson/Friend 1409 Anna Marie Court, Annapolis, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Nov 30 2010 | Rockville, MD Parklawn Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service-Licensee DeVol Funeral Home MO1117 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neumoni rs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause Classes or injury that in light and on the cause of the c Examine Due to (or as a consequence of): the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician requires that the death certificate be Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery cate has been signed by the atte page 2 should be detached for a 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Ves 2 No certificate 1 ☐ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Plac of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending after death.

Director: Af
d in by the fu 1 □Yes 2 □No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

even

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0/105/7-

MD

Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Maryland		artment of tificate of			ene g. No. 0	0	39498
			Decedent's Name (First, Middle, Last)				2. Date of Death			3. Time of Death
	Physicia Medic		Clarence T. Simpson				Novembe:	r [™] 19, 2	2010	7:50 p ^d
	Examin	er	4a. Facility Name (if not institution, give street and number) 20790 Cove Road		4b. City, Town, Bivalve	or Location of Death		4c. County	of Death	0
	Funeral Director		5. Social Security Number 218-20-6106 6. Sex 1 M 2 G F 83	st <i>birthd</i> ay) Yrs.	If Under 1 Year Months Days		8. Date of Birth 10/19/19	527	9. Birthpl Countr V1rc	ace (State or Foreign Jinia
	nd now	_	Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Loc	cation				10	0d. Inside City Limits
	faryfar 8a-f sl tified	Director	Maryland Wicomico Biv	alve						1 🗆 Yes 2 🌁 No
	vith the N 23a or 2 st be no	eral Di	10e. Street and Number 20790 Cove Road		10f. Zip Code 21814	4	10	g. Citizen of W USA	hat Count	ry?
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give	If	Vas Decedent of l	Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America k, White, e	tc.
21215-0036	72 hours in "natura ledical Ex	Completed	3 ☐ Widowed 4 ☐ Divorced Year or Dates. Navy 15. Decedent's Education (Specify only highest grade completed)	(Give k	lent's Usual Occu kind of work done O NOT use retired	during most of work	sing 1	6b. Kind of Bu		
212	within giene. er thau		Elementary/Seconday (0-12) College (1-4 or 5+)	milit		,	1	U.S. Na	avy	
and	be filed antal Hyg ked oth c event,	To Be	17. Father's Name (First, Middle, Last) Clarence F. Simpson				ne (First, Middle, Ma et Fraize)	
Maryland	should by and Me		19a. Informant's Name/Relationship (Type, Print) Peggy Simpson/spouse			and Number or Run	al Route Number, C	ity or Town, Si	tate, Zip Co	ode)
ore, N	of Health of Health if item 2: r other t		20a. Method of Disposition 20b. Pla	ace of Dispos	sition (Name of natory or other pla	1		Oc. Location -	City or Tov	vn, State
Baltimore,	nit. Page artment ortant: I injury o		Laboural 2 Li Cremation 3 Li Nemoval nom State	d Poin	t Cemete	ry 11/2		Shad Po		
Ba	Dep.	<u> </u>	1/2 / Sland	. 5	01 Snow	Hill Rd.	, Salisbu	ry, MD	al As 2180	sociation 4
	anysician/		Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Do not ente	- 1	ng, such as cardiac		5		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death) a. Due to (or as a consequence)	ence of):	Vicar		eren			
	ed sit	Examiner	Sequentially list conditions, if any locing to immediate cause. Enter Underlying Cause (Disease or injury	ence of:					-	
	ate be execute ohysician and the burial-trans	al Exa	that initiated events c. The sulting in death) Last Due to (or as a consequence)	ence of):						
260	cate be physic the bi	edical	d							
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown IF FEMALE: 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnar Other (specify)	псу		23d. Dat Mor	e of deliver	ry Day Year
P.0.	requires that the de been signed by the should be detached	y Phy	Part II. Other significant conditions contributing to death but not resu	lting in the u	nderlying cause g	iven in Part I.	23e. Did toba	cco use contri	ibute to the	e cause of death?
rds,	equires leen sig hould be	eted k					1 🗆 Yes			ably 4 Unknown
Reco	Physician: The law r r this certificate has b aral director, page 2 sl	Completed					24a. Was an autopsy performe	ed2 d	rior to con leath?	sy findings available inpletion of cause of
ita	sician: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		_ Tot	Place of Death (Chec	~			(
Division of Vital Records,	ding Phys h. After this funeral di	sate: To	27. Manner of Death 28a. Date of injury (Month, Day, Year)	ER/Outpatien 28b. Time of injury	28c. Inju	4 □ Nursing H ry at	ome 5 Residen 28d. Describe how			
ivisio	or Atten after deat Director: in by the	Certificate:	Image: Accident of the properties of the propert	ne, farm, stre		100 2010	28f. Location (Stre City or Town,		er or Rural I	Route Number,
Ω	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	Medical	29a. Certifier Certifying Physician: To the best of my knowle (Check Medical Examiner: On the basis of examination	and/or investi	igation, in my opir	ion, death occurred a	t the time, date and	place, and due	to the caus	se(s) and manner stated.
	vithin To the	Σ	only one) 3 Certifying Nurse Practioner: To the best of my 29b signature and title of certifier	N lowleage, d	29c. Licen			d. Date signed		_
	10 8	_	30. Name and address of person who completed cause of death (Item)	23a) (Type, P	rint)	ec a	1 1/1	11	1100	17/6/12
	Stat	е	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ire,	Spre	FU BOX	7338	DISC	Y	14800
	Registra	ır	NOV 29 2010 Lineur	J. 196	avec				/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician/ 2010 iam vovember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner licomic Salisbury Rehabilitation & Nursing (Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) Funeral (Month, Day, 1 🗷 M 2 🗆 F 8 Director -526 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location with the Maryland notified at Director 1 Ves 2 No 28a-f ccomack nincoteaaue 10g. Citizen of What Country? 10e, Street and Number ö and Mental Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be r Funeral Main d permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner musonce. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. William Savage Baltimore, Maryland 21215-0036 ò 1 Never Married 2 X Married Yes, Give 1 ☐ Yes 2 🙀 No Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1942-1946 16b. Kind of Business Industry 15 Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mae rnest 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Boothe Daught ean 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Taylor Cemetery 22. Name and Address Facility Temperanceuille UA 11-27-2010 4 ☐ Donation 5 ☐ Other (Specify) hinadague, 21. Signature of Funeral Service Licensee Funzial Homz 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Imjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 → No 3 □ Probably 4 □ Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has l autopsy performed? 1 Yes 2 No within 24 hours after death.

Jo the Funeral Director: After this certificate 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) funeral director, Be ER/Outpatient 3 DOA ည 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work' 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check cnly one) 29d. Date signed (Month, Day, Year) ļ. N 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Villiam H. Robi M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day og Physician/ Month Year Leister Bryant Stottlemyer, Jr. 1235 AM December 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 22, 1 6. Sex Birthplace (State or Foreign Country) Funeral Months Days Hours Min. 1 🔀 M 2 🗆 F Director 215-36-6464 80 Maruland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event: the Medical Eventine. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 12 No Maryland Washington Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23708 Foxville Road 21783 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Natr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian orces? Navy 2 No 1949 Black, White, etc. <u>م</u> 1 Never Married 2 🔀 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 1953 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Printer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leister B. Stottlemyer, Sr. Minnie M. Eyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23708 Foxville Road Smithsburg, Maryland 21783 Mary Ann Stottlemyer (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State December 4 ☐ Donation 5 ☐ Other (Specify) Mt. Bethel Cemetery Foxville, Maryland 13, 2010 Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the line. Immediate Cause (Final Earysician/ disease or condition Medical resulting in death) onsequence of); Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to or as a consequence of attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performe 2 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: ၉ 1 Nnpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined building, etc. (Specify) Medical 29a. Certifier Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Signat d title of certif 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) efferson SM MUBURG 783 2 1. Date filed (Month, Day, Year) 32. Registrar's Sig State 4 Registrar